**Form for Facility: Contact Information to Facilitate Active Linkage to Care for Mothers**

**[Note:** This form is to be used to inform facilities of the need for active linkage to care for participant *mothers* who are newly diagnosed with HIV during survey household HIV testing or are known HIV+ but not in care. *Infants* with newly diagnosed HIV will be contacted directly via a household visit by study staff.]

***Measuring the impact of the [country name] program for prevention of mother-to-child transmission of HIV***

Dear Dr/Sir/ Madam in Charge

***Health Facility Selected by Participant for Care and Treatment***

The person whose particulars are described below has been identified as HIV positive during the study ***Measuring the impact of the [country name] program for prevention of mother-to-child transmission of HIV***. She has either been newly diagnosed with HIV based on household HIV testing or has known HIV infection but is not in care. She has selected your health facility to provide HIV care services, and has consented for the survey to share her contact information with the facility. Therefore, the [*study institution/sponsors*]requests that your institution contact the said person in accordance with the information provided herein, in order to ensure that the participant (and her child, if applicable) receives appropriate care. As part of the survey, the person also had a blood sample collected to confirm the HIV diagnosis using a test conducted at [*name of laboratory*]. Results will be delivered to this facility within 6 weeks, and they will be identified by the PTID number in the label below.

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| --- | --- | --- | --- |
| Date: | | |  |
| 1. Participant ID: | | |  |
| 2. Name of Participant: | | |  |
| 3. Age of Participant: | | |  |
| 4. HIV **Positive** Status: | | | Known HIV+ case not in care  New HIV+ Diagnosis during home-based HIV testing |
| Preferred Means of Contact | | | |
| 7. Telephone Call |  |  | Telephone Number: |
| 8. SMS/Text | | | Telephone Number: |
| 9. In person | | | Address: |
| 10. Observations: | | |  |

**1 Information for FACILITY Form: To be filled by interviewer during post-test, reviewed by team leader and handed to field supervisor/coordinator for submission to Health Facility when EA is competed.**