

MINISTRY OF HEALTH

HCT CLIENT CARD

SECTION A:

Serial No. _____

Date ____/____/____

Name of Health Unit _____ HSD _____ District _____

Is the centre static or an outreach? 1. Static 2. Outreach

Point of testing: e.g. Ward, OPD, Clinic _____

Client's Name: _____ Sex ____ Age ____

If Child (Below 14 years), Accompanied by: 1[] Mother 2[] Father 3[] Guardian
(Specify) _____

Address: Village _____ Parish _____ Sub county _____

SECTION B

Pre-test counseling done/information given: Yes = 1 No = 2 Counseled as: Individual = 1 Couple = 2 Group = 3 Approach used (a)VCT (b)PITC (c) HBHCT (d) PMTCT (e) Mandatory (f) HCT for PEP (g) HCT for Circumcision (SMC)Marital status: Married/cohabiting Divorced/separated Widowed Never married

Number of sexual partners in the last 12 months _____

Have you ever tested for HIV before? Yes = 1 No = 2 Previously tested for HIV in last: 3months 6 month 12 months Results at: 3 months: positive Negative 6 months: positive Negative 12 months: positive Negative Has your spouse / partner been tested for HIV before? Yes = 1 No = 2 Don't know = 3

If yes what were the results?

1. Positive 2. Negative 3. Don't know

CLIENTS' SLIP

Serial No. _____

Date ____/____/____ Client's Name: _____ Sex ____ Age ____

District Name _____ Health Facility _____

Test Results: Positive Negative Referral notes:

Counselor's Name: _____ Date ____/____/____

CONSENT

I _____ having received pre-test counseling from my counselor hereby voluntarily decide and consent for an HIV test.

Signature _____ Date ____/____/____

TEST RESULTS:

HIV Results: HIV Negative HIV Positive

Test done by (Name) _____ Designation _____ Date ____/____/____

Results Received: Yes No

Results Received as a couple: Yes No

Couple results: Discordant Concordant

Is there suspicion of TB (cough for 3 /52, fever and night sweats)? Yes No

Has client started Co-trimoxazole prophylaxis? Yes No

Has client been linked to care or any other service? Yes No

Counselor's Name: _____ Date ____/____/____