LINKAGE TO HIV SERVICES WITHIN THE HEALTH FACILITY FORM

Complete a separate form EACH patient. If referring a pregnant woman for both EID and ART clinic services , fill two separate forms one for the mother and one for the unborn baby.

THE REPUBLIC OF UGANDA

Referred From:_____ Clinic To _____ _____Clinic **Date of Appointment**___/_____/_____

Date of referral:_____/_____/_____ **Referring Officer**_____

Reason for referral:

Reason for referral: (Tick only one)

☐ **HIV – exposed infant** referred to EID Care Point for testing /care

☐ **HIV – Positive Pregnant Woman (Unborn Baby)** referred to EID Care point for DBS testing after delivery

Expected Date of Delivery (EDD):_____/ _____/ _____

☐ **HIV – Positive Pregnant Woman** refered to ART Clinic for care/ treatment (from PMTCT)

PMTCT Regimen:_____ Most recent CD4 Count:_____

☐ **HIV – Positive child or adult** referred to ART Clinic for care/ treatment

☐ Initiating care/treatment at an HIV clinic (new patient)

☐ Already in care/treatment at an HIV clinic (transfer patient)

☐ **HIV- Positive child or Adult** referred to TB Clinic for care / treatment

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Patient Information

Name of Patient: _____ _____ _____ Age: ____ Sex: ☐ M ☐ F

Surname First Name

ANC #: _____ Pre-ART #: _____ART #: _____ EXP #:_____ TB No:_____

Referred from ANC Transfer or Initiating ART Transfer patient HIV-exposed infant

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Patient Care & Treatment History:

a) *Date of enrollment at ART clinic: ____/____/____

b) *Has patient been started on ART? ☐ Yes ☐ No

If yes, date of initiation: ____/____/____ Current regimen: _____

c) WHO Staging: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Not Documented

d) Most recent CD4 count: _____ %: _____ Date: ____/____/____

*Complete only if patient has already been enrolled at an ART Clinic

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Patient/Caregiver Follow-Up Information

Name of Caregiver (if child patient): _____ Common name used: _____

Patient/Caregiver's telephone number: _____ If child patient, caregiver's ANC #: _____

District: _____ County: ___ _____ Sub County: ___ _____Village: _____Parish: ___ _____

LC1 Zone: ___ _____LC1 Chairman: __ _____ -

Directions to patient's home:

Alternate Contact Person

Name: _____ Telephone #: ___

Relationship: ____ Has this person been disclosed to? ☐ Yes ☐ No

To be completed by destination ART or pre-ART Clinic:

Date Received: _____/_____/_____ Receiving Officer: _____

Did patient attend? ☐ Yes ☐ No If no, was follow-up initiated? ☐ Yes ☐ No

First follow-up attempt: _____ Date: ___/___/___ Outcome: _____