World Health Organization

CONSOLIDATED GUIDELINES ON

PERSON-CENTRED HIV PATIENT MONITORING AND CASE SURVEILLANCE

ANNEX 2.3.4

GENERIC HIV CARE/ART TRANSFER OR REFERRAL/COUNTER-REFERRAL FORM

JUNE 2017

Annex 2.3.4 Generic HIV care/ART transfer or referral/counter-referral form

Date: Referring facility:	Phone number: District:
Referral to:	Reason:
Unique ID:	
First name:	Last name:
Date of birth:	Address:
Date confirmed HIV+:	ART start date:
Original 1st-line regimen:	1st substitution: Date: Why:
	2nd substitution: Date: Why:
2nd-line regimen: Date:	1st substitution: Date: Why:
	2nd substitution: Date: Why:
3rd-line regimen: Date:	1st substitution: Date: Why:
	2nd substitution: Date: Why:
Most recent CD4: Date:	Most recent VL: Date:
☐ Pregnant EDD: ☐ Breastfeeding	☐ on TB prev. therapy ☐ on TB Rx, start date:
Drug allergies, other relevant conditions or medications:	
Other relevant clinical notes:	
Signature:	
Counter-referral form (complete and return to referring facility)	
Date received:	Receiving facility:
Signature:	Phone number: