



**TRANSFER OF ART PATIENT BETWEEN SERVICE POINTS**

<b>Transfer to:</b> Service Point: _____ District/Metro: _____ DC No.: _____ Province: _____ Tel: _____ Fax: _____	<b>Transfer from:</b> Public sector <input type="checkbox"/> NGO/FBO/CBO <input type="checkbox"/> GP <input type="checkbox"/> Other non-public <input type="checkbox"/> Facility Name: _____ District/Metro: _____ DC No.: _____ Province: _____ Tel: _____ Fax: _____ Mail address _____
Patient's contact details: _____	

**PATIENT IDENTIFIER**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of birth 

dd	mm	yy		

Sex  M  F Tel: \_\_\_\_\_ Current file No: \_\_\_\_\_ ID 

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Parent/guardian: (if applicable) First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Tel: \_\_\_\_\_

**PATIENT HISTORY**

<b>Baseline ART</b> ART start date <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">dd</td><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table> Regimen 1a <input type="checkbox"/> Any child regimen Regimen 1b <input type="checkbox"/> (if different to 1a or 1b) Specify baseline ART regimen if not 1a or 1b: _____						dd	mm	yy			<b>Baseline Lab (at start of ART)</b> CD4 _____ % CD4 _____ cells/mm <sup>3</sup> VL _____ copies/ml <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table> ALT _____ U/l Ery _____ x10 <sup>12</sup> /l HB _____ g/dl HCT _____ l/l Leuc _____ x10 <sup>9</sup> /l Lymph _____ x10 <sup>9</sup> /l Neut _____ x10 <sup>9</sup> /l Platelet _____ x10 <sup>9</sup> /l Gluc _____ mmol/l Cholest _____ mmol/l					mm	yy			<b>Baseline clinical status (at start of ART)</b> Weight (kg) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Height (cm) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> WHO Clinical Stage Adult <input type="checkbox"/> WHO Clinical Stage Child <input type="checkbox"/>							
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mm	yy																										

<b>Current ART</b> Current regimen since <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table> Regimen 1a <input type="checkbox"/> Regimen 2 Regimen 1b <input type="checkbox"/> Any child regimen (if different to 1a or 1b) Specify current ART regimen if not 1a/b/ or 2: _____ ART drugs issued will last until <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">dd</td><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table>					mm	yy								dd	mm	yy			<b>Most recent Lab</b> CD4 _____ % <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table> CD4 _____ cells/mm <sup>3</sup> VL _____ copies/ml <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table> ALT _____ U/l Ery _____ x10 <sup>12</sup> /l HB _____ g/dl HCT _____ l/l Leuc _____ x10 <sup>9</sup> /l Lymph _____ x10 <sup>9</sup> /l Neut _____ x10 <sup>9</sup> /l Platelet _____ x10 <sup>9</sup> /l Gluc _____ mmol/l Cholest _____ mmol/l					mm	yy							mm	yy			<b>Current clinical status</b> Weight (kg) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> WHO Clinical Stage Adult <input type="checkbox"/> WHO Clinical Stage Child <input type="checkbox"/> <b>Current Prophylaxis:</b> Cotrimoxazole No <input type="checkbox"/> Yes <input type="checkbox"/> Fluconazole No <input type="checkbox"/> Yes <input type="checkbox"/> Prophylaxis issued will last until <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">dd</td><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table>									dd	mm	yy		
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**REASON FOR TRANSFER / other relevant details:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Transfer date 

dd	mm	yy		

 First appointment made at receiving service point No Yes Appointment date 

dd	mm	yy		

Clinician's name \_\_\_\_\_ Signature \_\_\_\_\_ Tel \_\_\_\_\_ Fax \_\_\_\_\_

<p><b>ACKNOWLEDGEMENT OF TRANSFER</b> (to be completed by receiving service point)</p> <p>We have received the transfer notice. Received date: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">dd</td><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table></p> <p>Please fax <input type="checkbox"/> mail <input type="checkbox"/> to us: ART Assessment and Baseline form <input type="checkbox"/>                  Any previous Transfer forms <input type="checkbox"/> ART Patient Follow Up forms/details <input type="checkbox"/>                  Fax/send back copy of whole form to transferring service point immediately after receiving it!</p> <p>Clinician's name _____ Tel _____ Fax _____</p>						dd	mm	yy			<p>Patient has attended his/her first visit at our service point.</p> <p>Date of visit: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">dd</td><td style="text-align: center; font-size: 8px;">mm</td><td style="text-align: center; font-size: 8px;">yy</td><td colspan="2"></td></tr></table></p> <p>Fax/send back copy of whole form to transferring service point immediately after first visit!</p> <p>Clinician's name _____</p>						dd	mm	yy		
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