ANNEX 2.

ART CENTER REFERRAL FORM

(To be filled in duplicate by PHI MO. One copy for patient, one for record)

ART Centre (location, address):

Dear Doctor,

I am referring _____ Age, _____ Sex,_____who is a diagnosed HIV-infected TB patient to your ART centre for further evaluation.

(If applicable: Type of TB Case & TB number……)

Referring Doctor: ***Contact Phone #:***

Name & signature: ***Date: _____***

Name & address of the PHI: ***District:***

TU Name:

Details regarding ART

(to be filled by the ART medical officer and sent to the referring PHI through the patient)

Pre-ART Registration Number:_____

CD4 Count: _____

Patient Started On ART -If Yes ART Reg. Number_____

If No, reason:

Patient started on CPT - Yes / No

If No, reason:

Additional information:

Name & signature of the ART MO ***Date***