FEDERAL MINISTRY OF HEALTH

HIV CARE/ART TRANSFER AND REFERRAL FORM

Referral No. ________________ Card No.____________ Unique ART No. ______________________ Date of referral ______/______/____
(For all date use Ethiopian Calender in MM/DD/YY/Format)

Transferring/ Referring health facility ____

Transferred/ Referred to____

Patient full Name ______________________________ **Age** ________ **Sex** ________

Address: Region ______________________ **Zone**__________ **Woreda/Subcity**______________

Kebele (PA)______________________ **House No.**__________ **Tel. No.** ______________

1. Date confirmed HIV+ __________/_________/_________
   Patient started on ART ☐ No ☐ Yes
2. Why eligible for ART
   WHO Stage______ CD4 (/mm³ or %)______TLC (/mm³)_______ Transferred in form______________
3. Date ART Started ________/ _______/ ________
4. Original 1st line regimen & dose ______________________________
5. Current regimen & dose ______________________________
6. Reason for changing ART *(if applicable enter the reason for last change: use separate sheet if multiple changes)*
   Side effects (specify)____
   Rx failure (specify criteria)____
   Other (specify)____
7. Last entry for ART adherence: ☐ Good ☐ Fair ☐ Poor
8. Other Current medications
   Cotrim ☐ No ☐ Yes (Start Date)_____/____/____ INH ☐ No. ☐ Yes (Start Date) ____/____/____
   TB RX ☐ No ☐ Yes (Start Date) _____/____/____ Flucon. ☐ No. ☐ Yes (Start Date) ____/____/____

9. Past ARV use for PMTCT
   Did patient or patient's mother (for children) received ARV for PMTCT
   Mother ☐ No ☐ Yes date____/_____/_____ Child ☐ No ☐ Yes date _____/_____/_____
   ARV used for PMTCT ☐ Nevirapine ☐ Other (specify) ______________________

10. Summary of other information

	Lab data					Summary of findings			
	LFT (IU/L)	RFT	TLC	CD4 (or CD4 %)	Viral Load Copies/mm³	wt (kg) Ht (cm)	Body surface area	WHO stage	Func. Status
Baseline									
Current									

11. Reason for transfer/ referral
    ☐ Change of address ☐ Closer to patients' home
    For better management (specify reason) ______________________________
    Any other reason (specify) ______________________________
12. Transferring/ referring clinician
    Name ______________________ Signature ______________________
    Telephone ______________________ E-mail ______________________

Use the intake and follow up forms to fill this form
Use EC in dd/mm/yy format for all dates

Age record
Months for children <5yrs

Tr ART vrn 98