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|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Health - documents** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **REFERRAL LETTER**  **FROM KZN Door – Door Testing (CHAPS) FOR FOLLOW-UP CARE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Door to Door Client Number: | | | | | | | | | | | | | |  | |  | | |  | | |  | | | |  | | |  | |  | | |  | | | |  | | | | | |  | | | |  | |  | | | |  | |  | | |  | | | |  | | | |  | | |  | | |  | |  |  | |  | |  | | |  | | |  | | | | |
| Client referred to (clinic): | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Gender | | | | | | | | | | | | | | | | | | | M | | | | | F | | | | | | |
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| Please see the following client for follow-up care: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Client Data | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Name | | | | | | | | | | | | | | First Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Surname: | | | | | | | | | | | | | | | | | | | |
| 2. Date of Birth (DD/MM/YYYY) | | | | | | | | | | | | | | / / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3. Gender | | | | | | | | | | | | | | | | | | | | | | | | | Male Female | | | | | | | | | | | | | | | | | | | |
| 4. Cell phone number(s) | | | | | | | | | | | | | |  | | |  | | |  | | | | | **–** | | |  | | | |  | | | |  | | | | | |  | | | | |  | |  | | | |  | | |  | |  | | | |  | | | |  | | | **–** | | |  | | |  |  |  | |  | |  | | | |  | | | | | |
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| Clinical Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.Overal HIV test result | | | | | | | | | | | Reactive | | | | | | | | | | | | Non-Reactive | | | | | | | | | | | | | | | | | 3.Date tested/ screened: (DD/MM/YYYY)  / / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.Pregnancy test | | | | | | | | | | | Positive | | | | | | | | | | | | Negative | | | | | | | | | | | | | | | | |
| TB Screening Outcome | | | | | | | | | | | Positive | | | | | | | | | | | | Negative | | | | | | | | | | | | | | | | | **1.Weight Loss**  **2.Cough (Y/N)**  **3.Blood Stained Sputum (Y/N)**  **Cough >** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **4.Loss of Appetite** | | | | | | | | | | | | | | | | **Y** | | | | **N** | |
| **2.Cough** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **5. Blood stained Sputum** | | | | | | | | | | | | | | | | **Y** | | | | **N** | |
| **3.Weight Loss** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **6. Night Sweats** | | | | | | | | | | | | | | | | **Y** | | | | **N** | |
| STI Screening | | | | | | | | | | | Positive | | | | | | | | | | | | Negative | | | | | | | | | | | | | | | | | **1.Painfullness** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **5.Genital Sores** | | | | | | | | | | | | | | | | Y | | | | N | |
| **2.Discharge** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **6. Painful urination** | | | | | | | | | | | | | | | | Y | | | | N | |
| **3. Itchiness** | | | | | | | | | | | | | | | | | | | | **Y** | | | | **N** | | | | **7. Other** | | | | | | | | | | | | | | | | Y | | | | N | |
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| Other Referral Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Thank you very much, | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | *Name* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | *Signature* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ✁ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL FEEDBACK CARD** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *Please kindly complete the* ***Date of Client’s Arrival****, detach  this card and drop it into the “MSF Referral Box”. Thank you!* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D2D Client NNumber |  |  | |  |  |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | |  | | | | | | Date of Client’s Arrival (DD/MM/YYYY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | / / | | | | | | | | | | | | | | | | |
| Name | | | First Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Surname: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth (DD/MM/YYYY) | | | | | | | | | | | | | / / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Gender | | | | | | | | | | | | | | | | | | | | | | | | | Male / Female | | | | | | | | | | | | | | | | | |
| Date of screening/ Testing | | | | | | | | | | | | | / / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reason for referral: | | | | | | | | | | | | | | | | | | | | | | | | | HIV | | | | | | | | | | | Y | | | | | N | |
| TB | | | | | | | Y | | N | | | | Pregnancy | | | | | | | | | | | | | | | | | | | | | | Y | | | | N | | | | | | | STI | | | | | | | | | | | | | | | Y | | | | N | | | | | | Other | | | | | | | | | | | Y | | | | | N | |
| Referred By CHAP: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |