|  |  |  |
| --- | --- | --- |
|  |  | **Health - documents** |
|  |
| **REFERRAL LETTER****FROM KZN Door – Door Testing (CHAPS) FOR FOLLOW-UP CARE** |
|  |
| Door to Door Client Number: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Client referred to (clinic): |  | Gender | M | F |
|  |
| Please see the following client for follow-up care: |
|  |
| Client Data |
| 1. Name | First Name: | Surname: |
| 2. Date of Birth (DD/MM/YYYY) | / / | 3. Gender | Male Female |
| 4. Cell phone number(s) |  |  |  | **–** |  |  |  |  |  |  |  |  |  |  |  | **–** |  |  |  |  |  |  |  |
|  |
| 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 |
|  |
| Other Referral Details |
|  |
| Thank you very much, |  |  |  |
|  | *Name* |  | *Signature* |
|  |
| ✁ |
| **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: |  |