This book is numbered

from..............to..............

REPUBLIC OF ZIMBABWE

MINISTRY OF HEALTH AND CHILD CARE

MOHCC Community Referral Tool

Province:..

District:...

Name of Catchment Health Centre: ....

Health Facility Code: ....

Time Period of Register:From..............................**To**...

Version 1 January 2016

Serial No:

Part A: Services referred for to be filled out by the organisation making the referral	
Referring Organisation/Facility:	**Referring Officer(Name and Contact Details)**
Please receive (Client Surname): **(First Name):**	**First Name of Client's Mother/Caregiver** *(Only for children and adolescents):*
Sex: M F **Marital Status (circle):** Married. Single. Widowed. Divorced.	**Client Programme ID N°** *(Which could be ANC/PMTCT/ART)* Please indicate:
Date of Birth: ____________________ **Age:** ________________________	**National ID N°:**
Telephone No	**District:** **Community/Facility:**
Referred to (site/department/organisation):	**Date Referred:** **Expected Visit Date:**

Circle below the services you are referring this client for. (Multiple Response) If other please specify

01 Pre-ART registration	**11 HIV Rapid Test/HTS**	**20 Post Exposure Prophylaxis**	**28 CARG enrolment**
02 ART Initiation	**12 ART official transfer**	**21 PrEP**	**29 Cancer of Cervix Screening**
03 ART refill (defaulters)	**13 ART reinitiating (LTFU) or Stopped**	**22 Psycho-social support**	**30 Victim Friendly Services (Police, courts)**
04 ART Decentralization	**14 CD4 Count**	**23 Support Groups eg CATS**	**31 Legal counsel**
05 PMTCT/Option B+	**15 FBC Test**	**24 TB screening/management**	**32 Educational**
06 CTX/OI Management	**16 LFT Test**	**25 Family Planning**	**33 Emergency Shelter**
07 Economic Strengthening	**17 U&Es Test**	**26 VMMC**	
08 Emergency contraception	**18 Viral Load Test/HTS**	**27 STI –screening /treatment**	
09 Pre-Art Counseling	**19 DBS- PCR HIV Testing**		
10 Enhanced Adherence Counseling			

32 Other (Specify):

Tick in the box when feedback is received *(to be completed of the carbon copy which stays)* ☐ **Date Feedback Received:**

Serial No:

Part B: Services Provided to be filled out by the organisation fulfilling the referral *(if at facility tear off and keep in the box for community organization to collect, if at community tear off and return to referring facility/organisation)*

We have seen (client's full name):	**Client Programme ID N°** *(Which could be ANC/PMTCT/ART)*

At (Site/Department/Organisation):

Circle below the services you have offered this client. If other please specify

01 Pre-ART registration	**11 HIV Rapid Test/HTS**	**20 Post Exposure Prophylaxis**	**28 CARG enrolment**
02 ART Initiation	**12 ART official transfer**	**21 PrEP**	**29 Cancer of Cervix Screening**
03 ART refill (defaulters)	**13 ART reinitiating (LTFU) or Stopped**	**22 Psycho-social support**	**30 Victim Friendly Services (Police, courts)**
04 ART Decentralization	**14 CD4 Count**	**23 Support Groups eg CATS**	**31 Legal counsel**
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08 Emergency contraception	**18 Viral Load Test/HTS**	**27 STI –screening /treatment**	
09 Pre-Art Counseling	**19 DBS- PCR HIV Testing**		
10 Enhanced Adherence Counseling			

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Comment on services not provided as well as follow up information:

Name of Service Provider:	**Position:**	**Date services provided:**

PART C: FEEDBACK TEAR OF SLIP *(slip to be given to the person referring so that they tick referral as complete)*

Date	**Client Programme ID N°** *(Which could be ANC/PMTCT/ART)* Please indicate:	**Services provided (use code)**	**Further referral (Y/N)**	**Place & services referred for**

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