Annex 1.

Integrated Counselling and Testing Centre referral form

Referral to Integrated Counselling and Testing Centre

Dear Counsellor,
The patient with the following details is being referred for VCT to your centre:

Name _____*age/sex*
TB Number (if available) _____
Kindly do the needful and provide me feedback on the same, in a confidential manner.

Referring Provider

Name: **Contact Phone #:**

Date of referral:

Name and address of the PHI:

Feedback by the Counsellor to referring provider

(To be filled in duplicate by the counsellor. One copy for patient, the other for referring MO)

TEST RESULT FROM ICTC

HIV positive ☐ **HIV negative** ☐
Indeterminate ☐ **Opted out** ☐

PID Number

Date of conducting test

Additional communication to the referring physician

Signature of MO ICTC/counsellor