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