BASICS PEDIATRIC HIV TOOLKIT

COMPREHENSIVE REFERRAL AND COUNTER REFERENCE TOOL

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Comprehensive Referral and Counter Reference Tool

Form for the referral of sick children within the community

DATE :............../............. /............. Hospital No :...... ....

1. IDENTIFICATION: a) Name of Child : ....

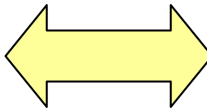
b) Name of Mother :............................ .... c) Name of Father:..

d) Adresse : District .... e) Sector ....f) Village :.....................................

g) Telephone :... h) Alternative Contact Number...

i) Sex M F j). Age (months/years) .... k. Weight .....Kg.......

2. REFERRING CENTRE/SITE (REFERRING FROM) (Check one and insert name)
☐ Health Centre
☐ Hospital
☐ Communaute (CHWs)
☐ Association PVVIH
☐ NGOs
☐ Schools/Orphanages/Nutrition Centres
☐ TBA/Traditional Healer
☐ Others (Specify)................................



3. RECEIVING CENTRE (REFERRING TO) (Check one and insert name)
☐ Reference Hospital
☐ Hospital
☐ Health Centre
☐ Community (CHWs)
☐ Association PVVIH
☐ NGOs
☐ Orphanages
☐ Others (Specify)........................

4. REASON (S) FOR REFERRAL (Check all that apply) Use space at the back for additional clinical information

☐ VCT	☐ Birth Spacing Family Planning	☐ Delivery	☐ Psychosocial Support	☐ Association of PVVIH
☐ PMTCT	☐ TB/HIV	☐ OVC	☐ Nutritional Counseling/Support	☐ Income Generation
☐ ARV	☐ Adherence Counseling	☐ Follow-Up	☐	☐ Educational Support
☐ Cotrimoxazole prophylaxis (CTZ)	☐ Palliative Care	☐ Newborn Care	☐ Life Skills Training	☐ Others

Date of next Appointment :............................ Name of Referring Officer :..............................

5. SERVICES PROVIDED (Check all that apply) Use space at the back for additional clinical Information

☐ VCT	☐ Birth Spacing Family Planning	☐ Delivery	☐ Psychosocial Support	☐ Association of PVVIH
☐ PMTCT	☐ TB/HIV	☐ OVC	☐ Nutritional Counseling/Support	☐ Income Generation
☐ ARV	☐ Adherence Counseling	☐ Follow-Up	☐	☐ Educational Support
☐ Cotrimoxazole prophylaxis (CTZ)	☐ Palliative Care	☐ Newborn Care	☐ Life Skills Training	☐ Others

-------------------------------------(Cut this part and give to patient to give to referring centre)--

6. FEEDBACK (Check all that apply) Use space at the back for additional clinical information

Name of patient: Hospital No.

☐ Seen	☐ Patient/Client Transfered to another facility
☐ Seen and Service Provided	☐ Patient to return for further evaluation on Date:
☐ Patient Admitted (Hospitalization)	☐ Others (Specify)

Name of Receiving Officer :..............................

ADDITIONAL INFORMATION ON REFERRAL

Referral Form in triplicate. Keep one copy with referring centre, one copy with receiving centre and the last copy to the patient)

Additional Clinical Information

1. PATIENT'S IDENTIFICATION INFORMATION:
a. Fill in patient's information including address, contact information, age and sex and other relevant identifier for the patient.
b. Also include alternative contact information for reaching out to the patients.

2. REFERRING CENTRE:
a. This is the site the referral originates from, the primary source of referral, the place where the referral is initiated.
b. Possible sources of referrals include; hospital, health centre, community health workers, Association of people living with HIV, NGOs, schools, Orphanages, nutrition centres, youth and women organizations, TBAs and Traditional healers, Churches and religious organizations, Refugee camps, and prison; c. Check the centre or source that applies to you; d. Insert the name of the referring centre against the checked box.
e. Insert other sources if not listed above

3. RECEIVING CENTRE
a. This is the site that receives the patient that has been referred; b. This is filled by the referring centre
c. Possible sites that can receive referrals include; TRAC, Referral Hospitals, Research Centres, hospital, health centre, community health workers, Association of people living with HIV, NGOs, schools, orphanages, nutrition centres, youth and women organizations, Churches and religious organizations and others; d. Check the receiving centre that you are referring the patient to.
e. Insert the name of the receiving centre against the checked box; f. Insert other receiving centre if not listed above

4. REASON(S) FOR REFERRAL
a. Check all the reasons for referring patient to the receiving centre; b. This section should be filled by the referring centre
c. Possible reasons for referring patients include the following services: VCT, PMTCT, ARV, OIs, birth Spacing, TB/HIV, adherence counseling, delivery, OVC, follow up care, newborn health, IMCI, palliative care, HBM, psychosocial support, nutritional support and counseling, Association of PVVIH, educational support, life skills training, income generation and others; d. This section should be checked by the referring officer

5. SERVICES PROVIDED
a. Check against the box the service that has been provided for this patient; b. This section should be checked by the Receiving Centre
c. Services provided should be similar to the reasons for referral. If additional service is provided indicate this accordingly

6. FEEDBACK
a. Check each box that applies to the service you have provided for the patient
b. Detach the feedback section and give to the patient if using one form
c. If form in triplicate, give one copy to the patient, keep one copy in your referral file
d. Document this referral in your referral register
e. Insert date of receiving client and date for next appointment where necessary

7. FOLLOW UP & TRACKING OF REFERRALS: Suggested ways to track and follow up referrals include the following:

a. Keep a separate referral register for each centre or entry point to care if a large HC or Hospital
b. Make the referral forms available at all the centres you expect to receive referrals from
c. Provide counter reference for all referrals from and to your centre
d. Keep and provide monthly referral report to all the centres you received referrals from.
e. Hospitals should send referral report to health centres, who now confirm from their registers if patient followed through with the referral or not. If not patient will be followed up at the community by the HC
f. Health Centres should also send referral reports to its network and those places that sent referrals.
g. When visits are made to the health centre or hospital for other reasons, use the opportunity to check on referrals sent to that centre

8. WHAT TO DO AFTER FILLING REFERRAL FORM
a. Fill form in triplicate
b. Send two copies in the hand of the patient and keep one copy in your folder
c. Record this referral in your referral register
d. Include referrals in your facility monthly reports