HIV/AIDS Cross Borders Referral Form

Confidential

Referral No./ID No. ..... Referral Date .....

Refer From ..... Refer To .....

Fullname ..... HN.....

Date of Birth ..... Age ..... Gender ☐ Male ☐ Female Occupation .....

Address in Thai .....

Address in Destination .....

Phone No. ..... Alternative No. .....

Contact name & status relationship ..... Phone No. .....

Contact Address ....

Background History (present illness , past history , OI) .....

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Laboratory Data

HIV testing Result..... Test Date_____/_____/_____

Latest CD4 .....cells/µl (.....%) Test date_____/_____/_____

Latest Viral load ..... copies/ml Test Date_____/_____/_____

CBC ..... Creatinine .....

HBs Antigen ☐ Negative ☐ Positive Test Date_____/_____/_____

Anti HCV (as If...) ☐ Negative ☐ positive Test Date_____/_____/_____

Syphillis.....or VDRL result ☐ Reactive ☐ Non-Reactive Test Date_____/_____/_____

Chest X ray result..... Test Date_____/_____/_____

Others .....

Current Medication .....

.....

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Reason for Referral ☐ start ART ☐ continuous treatment ☐ VL/cd4 testing

☐ other.....

Physician Signature.....

Physician Name .....

Designation.....

Department Organization ..... .

Email ..... phone no. .....

Acceptance Form

Referral No. .....

Receiving Hospital .....

Date of acceptance .....

Patient's name ..... Age .....

Gender ☐ Male ☐ Female

Registration No. .....

Action taken .....

.....

PHYSICIAN Signature.....

PHYSICIAN Name.....

Designation.....

Department Organization.....

Email ..... phone no. .....

THANK YOU FOR YOUR REFERRAL