

ID **A B J** - **0 0 2** - **0 0 0 1 1**
State Facility No. Serial Enrollment No.

Patient Name **Smith**
Surname

Theresa
Other Name

Hospital (Unit) No. **957355**

1. Patient Contact Address / Ph. Number **1000 Aguiyi Ironsi St, Maitama, Abuja, FCT / 09 - 413 - 5600**

2 a. Guardian Name _____


2 b. Guardian Contact Address / Ph. Number _____

3 a. Date of Missed Scheduled Appointment **01 / 05 / 2006** (DD/MM/YYYY)

3 b. Date of Last Actual Contact **01 / 03 / 2006** (DD/MM/YYYY)

4. Attempt to Contact

	Date	Who Attempted Contact?	Mode of Communication	Guardian Contacted	CHEW Contacted	Peer Supporter Contacted
a. 1st Attempted Contact	08 / 05 / 2006	Paul Grant	<input checked="" type="checkbox"/> Telephone <input type="checkbox"/> Home visit	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N
b. Other attempted contact	22 / 05 / 2006	Paul Grant	<input checked="" type="checkbox"/> Telephone <input type="checkbox"/> Home visit	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
c. Other attempted contact	01 / 06 / 2006	Paul Grant	<input type="checkbox"/> Telephone <input checked="" type="checkbox"/> Home visit	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
d. Other attempted contact	____/____/____	_____	<input type="checkbox"/> Telephone <input type="checkbox"/> Home visit	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
e. Last attempted contact (after 3 months)	____/____/____	_____	<input type="checkbox"/> Telephone <input type="checkbox"/> Home visit	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N


 Signature of Contact Tracer

Date **02 / 06 / 2006**
DD/MM/YYYY


5. Patient Care Terminated? Y N

6. Reason for exit from program:

- a. Lost to Follow up
- b. Dropped out of Care
 - Self Discontinuation
 - Transfer to another facility no.
 - Moved out of Area
 - Other (Specify) _____
- c. Death **28 / 05 / 2006**
 - Suspected ARV Side effect (specify) _____
 - Suspected Opportunistic Infection (specify) **TB**
 - Other cause of death _____
 - Unknown _____

Date of Termination **02 / 06 / 2006**
DD/MM/YYYY

Bobby White
 Clinician Name


 Clinician Signature

 Consultant Name

 Consultant Signature