Logo - Federal / State Ministries

Contact Tracking & Termination Form

<Area reserved for FMOH or SMOH seal>

ID [ ][ ][ ] State [ ][ ][ ] Facility No. [ ][ ][ ][ ][ ] Serial Enrollment No.

Patient Name _____ Surname _____ Other Name

Hospital (Unit) No. _____

1. Patient Contact Address / Ph. Number _____

2 a. Guardian Name _____

2 b. Guardian Contact Address / Ph. Number _____

3 a. Date of Missed Scheduled Appointment _____ (DD/MM/YYYY)

3 b. Date of Last Actual Contact _____ (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	____/____/____	_____	○ Telephone ○ Home visit	○ Y ○ N	○ Y ○ N	○ Y ○ N
b. Other attempted contact	____/____/____	_____	○ Telephone ○ Home visit	○ Y ○ N	○ Y ○ N	○ Y ○ N
c. Other attempted contact	____/____/____	_____	○ Telephone ○ Home visit	○ Y ○ N	○ Y ○ N	○ Y ○ N
d. Other attempted contact	____/____/____	_____	○ Telephone ○ Home visit	○ Y ○ N	○ Y ○ N	○ Y ○ N
e. Last attempted contact **(after 3 months)**	____/____/____	_____	○ Telephone ○ Home visit	○ Y ○ N	○ Y ○ N	○ Y ○ N

_____ **Date** _____ DD/MM/YYYY

Signature of Contact Tracer

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 _____
- ○ Suspected ARV Side effect (specify) _____
- ○ Suspected Opportunistic Infection (specify) _____
- ○ Other cause of death _____
- ○ Unknown _____

Date of Termination _____ DD/MM/YYYY

_____ _____

Clinician Name **Clinician Signature**

_____ _____

Consultant Name **Consultant Signature**