Discontinuation Form

Date form completed: _____ / _____ / _____ (DD / MM / YYYY)

Name: | **Patient ID:** | **Site:**

Current ARV regimen: _____ , _____ , _____ 0 HAART 0 PPCT 0 None

↓ Reason for patient discontinuation

0 **Patient refused care**

Date refused care: _____ / _____ / _____ (DD / MM / YYYY) _____ Patient Signature _____ Patient ID

_____ Witness Signature

Reasons given: _____

_____

Source of information: ☐ Patient ☐ Friend/Relative ☐ Other, specify: _____

0 **Patient known/reported to be deceased**

Known date of death: _____ / _____ / _____ (DD / MM / YYYY)

Estimated date of death: _____ / _____ / _____ (DD / MM / YYYY)

Cause of death: _____ ☐ Unknown

Source of information: ☐ Death certificate ☐ Hospital records ☐ Reported by friend/relative ☐ Other, specify: _____

← 0 **Infant determined to be HIV-negative**

Date of last negative HIV test: _____ / _____ / _____ (DD / MM / YYYY)

Type of last HIV test: 0 DBS/PCR 0 Rapid antibody 0 ELISA

0 **Transfer of patient**

New PSC Patient ID: _____

Date of Transfer: ____ / _____/_____ (DD / MM / YYYY)

Clinic that the patient will transfer to: _____ District: _____

→ *Make arrangements for transfer of patient summary to the new clinic*

0 **Patient Lost to Follow-Up**

0 **Other (specify in comments below)**

Comments: _____

_____

_____

Form completed by: *(Print name clearly)*

CCHA: _____

Nurse: _____

Clinical Officer: _____

Medical Officer: _____