KwaZulu Natal Department of Health
Comprehensive Care Programme

FORM 7: ADULT PATIENT TRANSFER FORM

(Form filled in by Admin Clerk/Data Capturer)

Transfer To: *(Name of new Treatment Site)*

Site Code:

Date of Transfer: d d / m m / y y y y

Province:

○ NL ○ EC ○ FS ○ GT ○ LP ○ MP ○ NC ○ NW ○ WC

District Code:

Facility Type:

Telephone:

Fax:

Transfer From: *(Name of transfering Treatment Site)*

District Code:

Province: N L

Site Code:

Capturer:

Facility Type:

Telephone:

Fax:

A. PATIENT DETAILS

South African ID Number:

Telephone/Cell:

Patient Firstname:

Patient Surname:

B. REASON FOR TRANSFER

1. Please specify the reason for the transfer: ○ Closer Site ○ Change in Residential Address ○ Other

(If Other, Specify Reason) →

C. CLINICIAN DETAILS *(Details of clinician approving/handling the Transference)*

1. Fullname of Clinician:

2. Tel (work):

3. Tel (fax):

4. Signature:

(This section is filled in by the Site receiving the patient)

Has the first appointment been made: ○ Yes ○ No *If Yes, when* → d d / m m / y y y y

Date of receipt of Transfer Form: d d / m m / y y y y

Please fax/mail this section when completed to:

(Only enter numbers - No brackets or dashes)

Patient has attended first visit at new ART site: ○ Yes ○ No

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