BABY TESTING AND FOLLOW-UP REGISTER



Prepared by PMTCT/SRH Unit
Ministry of Health
Private Bag 00451
Gaborone, Botswana





Baby Testing & Follow-Up Register

Baby Testing & Follow-Up Register



								HIV Test 1 - Initial				HIV Test 2 - Confirm Positive				***							
Serial Number Date Sample Collected	Full Name of Sample Collector	Childs' Name (Surname first)	Nationality Gender (M/F) Date of Birth	Age Birth Certificate Number	Name of the Care Giver (Surname first)	Contact Physical Address and Telephone Nos.	Permanent Physical Address	Date of Test Reason for Test Test Type	(PCK/Kapid/ Elisa) HIV Test Result & and Date	Counselors' Full Name	Date of Test	Test Type (PCR/Rapid/Elisa) HIV Test Result and Date Post-Test	Counselors' Full Name	Start Stop Date Date	Date reffered to ARV Clinic Attendance Date of first ARV Clinic	Reg # at ARV Clinic Name of ARV Clinic	Date HAART Wint % Date	If not started on HAART give reasons	Any signs of serious illness** or other comment	Date of Death Awaiting Results	Awaiting Treatment While on Treatment Treatment	Comments	Full Name of Provider
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1 Nationality 1 = Citizen 2 = Non - Citizen

Reason for HIV Test
FT = First Test
SL = Sample Lost
PW = Post Weaning
CP = Confirmatory Positive
SB = Sick Baby

HIV Test Result

Pos = Positive

Neg = Negative

I = Indeterminate R = Rejected

* Redraw DBS after 8 weeks if results still pending

Baby Feeding Method

EBF = Exclusive Breast Feeding

EFF = Exclusive Formula Feeding

MF = Mixed Feeding

** Pneumonia, Diarrhoea, Failure to Thrive, Development Delays or Other Serious Illness

*** If HIV Negative, please write "N/A"



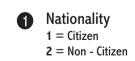


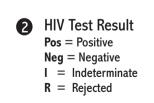
Baby Testing & Follow-Up Confirmation of HIV Negative Test from 18 Months

Baby Testing & Follow-Up Confirmation of HIV Negative Test from 18 Months

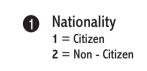


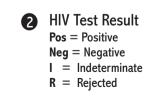
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Date of Test Childs' Name (Surname first)	Name of the Care Giver (Surname first) ID (Omang/Passport) Number	Contact Physical Address and (Rapid/Telephone Nos. Type of HIV Test (Rapid/Elisa)	Date Post- HIV Result Test and Date Counseled	Counselors' Full Name	Date Date of Reffered first ARV to ARV Clinic Clinic Attendance	Date started on ARV Commen	ents	Serial Number Date of Test	Childs' Name (Surname first)	Name of the Care (Surname firs ID (Omang/Passp Number	Giver t) Phy port) Tel	Contact . rsical Address and lephone Nos.	Type of HIV Test (Rapid/ HIV Result and Date	Date Post- t Test Counseled	Counselors' Full Name	Date Date of Reffered first ARV Clinic Attendance	Date started on ARV	Comments
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* If HIV Negative, please write "N/A"





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