

CLINIC ENROLMENT FORM

Name of C	ounty: Sub-county:
Ward:	Implementing partner:
Date of en	rolment (DD/MM/YYYY):/ MFL code:
KP unique	identifier code:
KP type (T	rick appropriate): FSW MSM MSW PWID PWUD Transman Transwoman
1	Name of KP:
2	Have you been contacted by a peer educator for any health services? 1.Yes 2. No
3	Do you have a regular non paying <u>sexual</u> partner? 1. Yes 2. No
4	a. Which year did you start sex work b. Which year did you start having sex with men (MSM only) c. Which year did you start using drugs (injecting or smoking) Year:
5	Have you ever experienced physical/sexual violence? 1= Yes
6	a) Have you ever been tested for HIV? 1= Yes 2= No If NO, skip to Q10 b) The last time you received HIV testing, how did you test? Rapid HIV testing Self-test
7	Would you like to share your LAST test result with me? (circle the number) 1= Yes, I tested positive 2= Yes, I tested negative 3= I do not want to share
8	If POSITIVE, are you receiving HIV care? 1= Yes 2= No (If NO refer to CARE)
9	If Yes (receiving care), ASK for the following; Facility Name: CCC number: Viral load test: 1. Yes 2. No Date of VL result:
10	Are you willing to be tested for HIV? 1= Yes
11	In case you are due for clinical services, could we contact you through: Phone
	Date: