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**Thailand-Myanmar Cross Border Referral Form**

Name ………………………………………. Age ………… Sex ………………

Referred from ……………………………. To …………………………………………

Registration No ………………………….

Referral No ………………………………. Date of referral \_\_/ \_\_\_/ \_\_\_\_\_\_\_

**Address (Please specify)**

Myanmar ………………………………… District……………………………………………. Thailand………………………………….. District……………………………………………….

Phone number:…………………………….

**Background history** (Any relevant Medical history + risk factor)

…………………………………………………………………………………………..

…………………………………………………………………………………………..

**Laboratory Data**

CD4 ……………………………(Date………………….)

Viral load………………………(Date………………….)

CBC..........................................

Creatinine………………………

HBs Antigen……………………

HCV Antibody…………………

CXR…………………………….

Others…………………………..

**Current Medication**

**(Please verify if you switch to ART second line regieme)**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

**Reason for Referral**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

Signature…………………………………………

Name………………………………………………

Designation………………………………………

Email………………………………………………

Department/Organization…………………………

If you have any questions about this referral, please contact ……………………………….…Email………………………………...Phone……………………….

**…………………………………….………**Description: C:\Documents and Settings\Administrator\Local Settings\Temporary Internet Files\Content.IE5\0XNZOXIS\MC900234170[1].wmf**………….………………………………………..**

**Acceptance Form**

Receiving Hospital ……………………………………..

Patient’s Name……………………………………………. Age……………… Sex…………….

Registration No…………………………………………..

Date of acceptance………………………………………...

Action taken…………………………………………………………………………………………

|  |
| --- |
| Signature……………………………….. |
| Name…………………………………..... |
| Designation……………………….……….  Email…………………………………….. |
| Department/organization…………………. |

**THANK YOU FOR YOUR REFERRAL**