**Form 1d: Services Checklist, Session Notes, & Enrollment in Care Outcomes**

| Client Name: | Sex: ❑ M ❑ F | Age (years): | EC ID: |
|---|---|---|---|
| HTC #: ______________________________ | Linkage Program ID: □-□□-□□/□□-□□□ | | |

**Transfer and Death** (*tick all that apply)*

Client transferred to a facility ***outside*** of the CommLink area: ❑ Yes If yes, transfer facility name: ________________________________________

Transfer Date: ____ /____ /____

Client transferred to a facility ***inside*** of the CommLink area: ❑ Yes If yes, transfer facility name: ________________________________________

Transfer Date: ____ /____ /____

Client died: ❑ Yes Date of death: ____ /____ /____

**Escort & Treatment Navigation Services** *(complete all boxes before case closure)*

| **Escorted to CTC by car?** | **Escorted to CTC by foot?** | **Met at CTC by appointment?** |
|---|---|---|
| ❑Yes ❑ No | ❑Yes ❑ No | ❑Yes ❑ No |

## I. Linkages Services Checklist

| | Assessment, Counseling, and Linkage Services Provided | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 |
|---|---|---|---|---|---|---|---|
| | **Date of Session** *(DD/MM/YY)* | / / | / / | / / | / / | / / | / / |
| **1** | **Assessment** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Wellbeing & coping | | | | | | |
| | Disclosure | | | | | | |
| | Pregnancy and breastfeeding | | | | | | |
| | TB symptoms | | | | | | |
| | Condom use | | | | | | |
| | PIMA CD4 test | | | | | | |
| **2** | **HIV Care Counseling** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Importance of HIV care | | | | | | |
| | ART helps prevent premature death | | | | | | |
| | ART helps prevent HIV transmission | | | | | | |
| | Importance of pre-ART care | | | | | | |
| | Discussed potential enrollment in EAAA | | | | | | |
| | Importance of CD4 and clinical staging | | | | | | |
| **3** | **CTC Information & Referral** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Most appropriate clinic to enroll in care | | | | | | |
| | Clinic hours & best days to enroll | | | | | | |
| | What to expect on first visit | | | | | | |
| | What to expect in Pre-ART and ART care | | | | | | |
| | Provided referral to CTC | | | | | | |
| **4** | **CTC Visit with Client** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Escorted client to CTC by car or foot *(activity)* | | | | | | |
| | Met client at CTC *(activity)* | | | | | | |
| **5** | **Partner and Family Testing** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Assessed and discussed disclosure to partner and family members | | | | | | |
| | Assessed and discussed HIV testing of partner and family members | | | | | | |
| | Discussed barriers and solutions to testing partner and family members | | | | | | |
| | Helped provide partner or family-member HIV testing services *(activity)* | | | | | | |

***Checklist continued on next page…***

| | Assessment, Counseling, and Linkage Services Provided | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 |
|---|---|---|---|---|---|---|---|
| **6** | **Barriers Assessment** *Tick if **any** services in this section are ticked* → | | | | | | |
| | Assessed and discussed barriers to care and treatment | | | | | | |
| | Provided informational counseling to reduce barriers | | | | | | |
| | Shared testimonials and personal experiences in overcoming barriers | | | | | | |
| | Provided other psychosocial support to help reduce identified barriers | | | | | | |
| | Explored potential resources the client might have or use to reduce barriers | | | | | | |
| **7** | **Post-enrollment in Care Assessment** *Tick if **any** services in this section are ticked* → | | | | | | |
| | CTC experiences | | | | | | |
| | Services received | | | | | | |
| | Quality of services (timeliness, respectfulness, professionalism) | | | | | | |
| **8** | **Client Risk Characteristics** *Tick if **any** risks in this section are ticked* → | | | | | | |
| | Client is at high risk for not accepting and enrolling in ART care (*explain below*) | | | | | | |
| | Client is at high risk for defaulting from ART care (*explain below*) | | | | | | |

## II. Linkage Session Notes

**Session 1**

**Characteristics:** ____________________________________________

____________________________________________

____________________________________________

**Needs:** ____________________________________________

____________________________________________

____________________________________________

**Plan:** ____________________________________________

____________________________________________

**Session 2**
**Characteristics:** ____________________________________________________________
____________________________________________________________
____________________________________________________________
**Needs:** ____________________________________________________________
____________________________________________________________
**Plan:** ____________________________________________________________
____________________________________________________________

**Session 3**
**Characteristics:** ____________________________________________________________
____________________________________________________________
____________________________________________________________
**Needs**: ____________________________________________________________
____________________________________________________________
**Plan:** ____________________________________________________________
____________________________________________________________

**Session 4**
**Characteristics**: ____________________________________________________________
____________________________________________________________
____________________________________________________________
**Needs**: ____________________________________________________________
____________________________________________________________
**Plan:** ____________________________________________________________
____________________________________________________________

**Session 5**

**Characteristics**: ______________________________

______________________________

______________________________

**Needs**: ______________________________

______________________________

**Plan:** ______________________________

______________________________

**Session 6**

**Characteristics**: ______________________________

______________________________

______________________________

**Needs**: ______________________________

______________________________

**Plan:** ______________________________

______________________________

**III. Adverse Events** *(Examples: Negative experience during a CTC visit; physical or psychological abuse; adverse reactions to CTX or ART, etc.)*

**Date of Event:**

**Description:** ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

______________________________________________

**Action Taken:** ______________________________________________

______________________________________________

______________________________________________

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______________________________________________

______________________________________________

**Date of Event:**

**Description:** ______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Action Taken:** ______________________________________________

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______________________________________________

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**LINKAGE PROGRAM METRICS AND QUALITY ASSURANCE**

**IV. Transition and Coordination of Care**

**Instructions:** After conducting the last CommLink session, meet with the CTC EC or counselor responsible for providing psychosocial and adherence counseling, and if applicable, the EC or nurse for the Early ART Program. Inform CTC providers about clients' status on partner disclosure, testing, and counseling, and potential barriers to retention in HIV care.

| **Met with CTC EC/Counselor:** |
| --- |
| ❑ Yes ❑ No ❑ N/A |

**V. Program Discontinuation**

| If client has not completed the program and is no longer participating *(tick one)*: | ❑ Refused continued participation<br>❑ Lost contact<br>❑ Moved / Extended travel |
| --- | --- |

**VI. Final Review & Case Closure**

I have met with the EC and reviewed all aspects of this case including the scope and timing of provided linkage services, and the completion of all program forms and variable fields. Linkage program expectations have been reasonably met by the EC, including the complete and accurate completion of all study forms. I approve closure of this case.

Linkage Supervisor Signature: ____________________________________________________ Date of Case Closure: ______ / ______ / ______