Most health facilities receive support from multiple partners, support groups and organizations who work together to provide patient care and support services. The goal of the **Referral Organization Information Form** is to create a comprehensive directory per site by obtaining information from each organization and group about their activities and services in order to collaborate and facilitate referrals. After obtaining information about each of the health facility's organizations, they can be combined in an easy to reference binder or poster, such as the **Referral Organization Summary**.

The **Referral Tracking Tool** is the last step in the process. This tool allows facilities the ability to track patient referrals to see if the referral was successful. This can provide valuable insight on how referral systems are working and patient barriers to attending referrals.

Referral Organization Information Form

(to be filled by organizations)

Name of Organization: _____

Status: □ Government □ NGO □ CBO/FBO □ School

□ Material or equipment supplier □ Other (specify): _____

Target Audience:
Describe the target audience for your program. (e.g. children below the age of 16, adults, all, HIV-infected individuals, etc.)

_____

Services Offered/Activities:
Describe your organization's main activities. Please try to keep the descriptions for your activities brief.

_____

_____

Cost for Services Offered? □ No □ Yes *(please attach document with price list)*

Outreach:
Tick below if you have an outreach program. If yes, please attach the location, dates, times, and services provided at your outreach center.

□ No, we do not have an outreach program. □ Yes, we do have an outreach program.

Contact Information:
Write N/A if not applicable. Cell number should only be filled if it is an official organization phone line.

Physical Address:			
Postal Address:			
Office Phone:		***Phone:***	
Fax:		***Cell:***	
Email:			
Website:			

Hours of Operation:
Please fill in your hours of operation for each day (e.g. 8am-4pm). If all of your services are offered on that day, please tick 'All', if not, tick 'Only' and specify which services are available on the lines provided.

	Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun
Time						
Service Provided	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____

Key Contact Personnel:
List the contact person for your organization below. Note that this person's name and title will be in the manual. Their personal email and phone information will NOT be listed in the manual, but will be used by Tingathe staff for further reference only.

Name			
Title			
Email		***Phone***	

Referral Organization Summary:

(compiled to be kept at the health facility for reference)

Organization Name	Key Activities	Contact Details *(name, phone number, email address)*	Location

Referral Tracking Tool

(kept at health facility for tracking purposes)

Site: _____ Month: _____

Date of Referral	Patient Name	Patient ART No.	Reason for Referral	Organization Referred To	Date of Follow-Up	Referral Successful?		Comments/ Outcome Details
						Yes	No	