REPUBLIC OF KENYA

MINISTRY OF HEALTH

CLINIC ENROLMENT FORM

Name of County: _____ Sub-county: _____

Ward: _____ Implementing partner: _____

Date of enrolment (DD/MM/YYYY): _____/_____/_____ MFL code: _____

KP unique identifier code: _____

KP type (Tick 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 **sexual** partner? 1. Yes ☐ 2. No ☐
4	a. Which year did you start sex work Year: _____ b. Which year did you start having sex with men (MSM only) Year: _____ c. Which year did you start using drugs (injecting or smoking) Year: _____
5	Have you ever experienced physical/sexual violence? 1= Yes ☐ 2= No ☐ (If yes, specify Physical / Sexual / Both) _____
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 ☐ 2= No ☐ If No, indicate reason _____
11	In case you are due for clinical services, could we contact you through: Phone 1. Yes ☐ 2. No ☐ Peer educator 1. Yes ☐ 2. No ☐ Outreach worker 1. Yes ☐ 2. No ☐ Clinician/HTS Counsellor 1. Yes ☐ 2. No ☐ Treatment buddy 1. Yes ☐ 2. No ☐ Name of the treatment buddy_____Telephone number of the treatment buddy_____ Signature /Thumb of the KP_____ Completed by: _____ Date: _____