Register for Facility Integrated/PPP ICTC

Name of the Health Facility……..								Month	……	Year	……
Sr.No.	Referred from (O&G)ANC/ Direct in Labour/RNTCP/ STI/ TI/ LWS/ Others	Full Name	Full Address with contact No-	Age In Years	Sex: Male, Female, TS/TG	Pre Test Counselling (Yes/No)	Date of HIV Test (dd/mm/ yyyy)	HIV Test Result (Reactive , Non Reactive)	Post Test Couselling (Yes/No)	Referred to Stand Alone ICTC for confirmation (Yes/No)	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
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