KENYA CLIENT FLOW FORM	Client No:			
Facility name: Entry unit: MCH _ Other: Date today: Client arrival time:: Sex of client: MaleFemale Age: DOB: Client type: Adult (alone) Adult with child (age of child) Client's residence: District: Division: Location: Instructions to client: Please take this form to each nurse, doctor or other counselor that you see during your visit at this clinic today. Please hand the form back in to one of the interviewers before you leave. Instructions to the provider: Please complete a new row for each client you see. Fill in the time that the client arrives, and the time the client leaves. In the first column, tick for each of the services that you provide to the client. If you refer the client somewhere else, tick the appropriate box(es) in the second column, and indicate if it was an internal or external referral (or both). If you do not refer the client on, leave question 2 blank.				
1 st Provider seen: Consultation start time: :	:::::			
1. What is client seen for? (tick all that apply) 1. Ante-natal care 2. Child immunization 3. Child welfare 4. Counseling (general) 5. Family planning counseling 6. Family planning provision 7. Gynecologist 8. HIV care (pre ART or ART) 9. HIV counseling 10. HIV testing (blood test) 11. Laboratory test 12. Pap smear 12. Pap smear 13. Pharmacy (drugs) 14. PMTCT 15. PNC baby (exam) 15. PNC baby (exam) 16. PNC mother (exam) 17. STI counseling 17. STI treatment 19. TB care/treatment 20. X-ray 21. Other (specify):	2. What is client referred for? (tick all that apply) Ante-natal care Pap smear Child immunization Pharmacy (drugs) Child welfare PMTCT Counseling (general) PNC for baby (exam) Family planning counseling PNC for mother (exam) Family planning provision STI counseling Gynecologist STI treatment HIV care (pre ART or ART) TB care/treatment HIV counseling X-ray HIV testing (blood test) Other (specify): Laboratory test Is this/are these: Internal referral(s) External referral(s) If external, where?			
2 nd Provider seen: Consultation start time:	Consultation end time: :::::::::::::::::::::::::::::::::::			
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3 rd Provider seen: Con	sultation start time::	Consulta	ation end time:		
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