

**Facility………………………… MFL Code..............................................**

**County......................................... Sub County...............................................................................**

**Date (dd/mm/yyyy)........................................Time ……………………….**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. 1. | Client Name: …………………………………………………………………….……… Nickname: ………………………………………………………. | | |
| 2. | Unique ID: ………………………………………………………….National ID/Passport Number: **……………………..** | | |
| 3. | Date of Birth (DD/MM/YYYY)……………………………… | | Age (2 digits)…………………………… |
| 4. | Sex | Male Female Others (specify ……………………………………………….) | |
| 5. | Sub county of residence | | ……………………………………………………………………………………………… |
| 6. | Physical address | | ……………………………………………………………………………………………… |
| 7. | Phone no. | | ……………………………………………………………………………………………… |
| 8. | New Transfer In  Have you ever received MAT Services elsewhere? Yes No If Yes MAT ID………………………. | | |
| 9. | Type of referral? (Tick One) | | Self GOK Facility Private Clinic CSO  Transfer from MAT clinic  Criminal Justice system Other Specify …………………………….. |
| 10. | Name of referring facility? | | …….…………….…………………………………………………………………………. |
| 11. | Referring facility’s client registration number | | …………………….………………………………………………………………………… |
| 12. | Accompanied by: | | Parent  Partner  Friend  Outreach worker  Other Specify ……………………………………….. |
| 13. | Peer Educator’s/ ORW Name | | ……………………………………………………………………………………………… |
| 14. | Peer Educator’s/ ORW phone number | | ……………………………………………………………………………………………… |
| 15. | Treatment supporter’s name | | ……………………………………………………………………………………………… |
| 16. | Treatment supporter’s phone number | | ……………………………………………………………………………………………… |
| Name of Service Provider:  ……………………………………………………………………………………………….. | | | Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |