Ministry of Health
Division of National Laboratory Service
National Public Health Laboratory (NPHL),
National HIV Reference Laboratory (NHRL), P.O. Box 20750-00202, Nairobi

CD4 REQUEST FORM

County:			
Sub-County:			
Health Facility:			
MFL CODE:			
Service Delivery Point:			
Start date:		**End date:**	

Version: 02 Effective: 27/07/2026

MINISTRY OF HEALTH
CD4 Request Form

CD4 request form Instructions/Definition of terms

CCC Number/UPI/SHA No.	Enter CCC number in the upper cell in the format (MFL-NNNNN) and in the lower cell enter System Generated National Unique Patient Identifier (UPI)SHA No.
Justification (code)	Indicate the following codes: **1**= Baseline for new client **2**= Treatment failure **4**. Interrupted treatment for >3 Months **5**. AHD (severely ill or hospitalized or when guiding prophylaxis discontinuation.
Date of Birth	Enter the client's Date of Birth in the format DD/MM/YYYY
Indicate CD4 test requested	Enter the following codes **1**=CD4 absolute count **2**=CD4 **%**
Sex(M/F)	Enter client's sex. Use **"M"** for Males and **"F"** for Females.
Date and time of collection	Enter Date in the format DD/MM/YYYY in the upper cell and time of sample collection in the format 00:00 Am/Pm in the lower cell.
Date started on ART	Enter Date client started ART in the format DD/MM/YYYY.
Current ART regimen	Indicate the following codes: **1**= Adults TDF/3TC/DTG **2** =Pediatrics ABC/3TC/DTG **3**= Others specify
Date Initiated on current regimen	Enter Date client was initiated on current regimen in the format DD/MM/YYYY.
Rejection	Enter **"Y"** if sample is rejected and **"N"** if sample is not rejected
	If sample is rejected indicate the following codes **1**=Missing Sample **2**=Hemolyzed sample **3**=Missing patient ID **4**=Sample request form & sample mismatch

MINISTRY OF HEALTH
CD4 Request Form

Facility Details

Facility Name: .....

MFL Code: .....

Facility/CCC email: .....

Facility/CCC telephone number .....

County: .....

Sub-county: .....

Clinician's Name: .....

Facility Laboratory details

Date & Time sample dispatched: .....

Lab focal person phone contact: .....

Testing laboratory

Date and time sample received: .....

Focal person phone contact .....

Focal person phone contact: .....

No	CCC No *Indicate full ccc number of the clients as it appears in the patient file.* (MFL-XXXXX) B	Justification code	DOB *(dd/mm/yyyy)*	Indicate CD4 test requested	Sex	Date & Time of collection *(dd/mm/yyyy)* 00:00 AM/PM	Date started on ART *(dd/mm/yyyy)*	Current ART Regimen *(Select from code below)*	Date initiated on current regimen (dd/mm/yyyy)	Rejection *(For reason select from code below)*	
										Y/N	*Reason*
A	B	C	E	F	G	J	L	M	N	O	P
1	CCC UPI/SHA No.					Date: Time:					
2	CCC UPI/SHA No.					Date: Time:					
3	CCC UPI/SHA No.					Date: Time:					
4	CCC UPI/SHA No.					Date: Time:					
5	CCC UPI/SHA No.					Date: Time:					

Indicate the following codes:

1= Baseline for new client **2**= Treatment failure **4**. Interrupted treatment for >3 Months **5**. AHD (severely ill or hospitalized or when guiding prophylaxis discontinuation.

Indicate CD4 test requested:

1=CD4 absolute count

2=CD4 **%**

Code for Sample Rejection **1**=Missing Sample **2**=Hemolyzed sample **3**=Missing patient ID **4**=Sample request form & sample mismatch

Current regimen

1. Adults TDF/3TC/DTG
2. Pediatrics ABC/3TC/DTG
3. Others specify