TOOL UTILIZATION AND DOCUMENTATION AUDIT FORM			
Name of Facility:			
Name of Auditor:			
Review Month:			
Date of Abstraction:			
TOOL UTILIZATION	**IN USE (YES/NO)**	**AVAILABLE STOCK**	**COMMENTS**
National ANC register			
National C&T in ANC register			
DOCUMENTATION AUDIT	**Enter yes if done, no if not done**	**How many clients were registered?**	**How many had this indicator documented?**
Are the demographics filled completely for all clients? Check the state, facility name, LGA, year, month, date of delivery, hospital reg no., ANC no., phone no., age, LMP, GA			
Is source of referral filled for all clients?			
TOTAL			
DOCUMENTATION AUDIT (National C&T in ANC register)	**Enter yes if done, no if not done**	**How many clients were registered?**	**How many had this indicator documented?**
Are the demographics filled completely for all clients? Check the state, facility name, LGA, year, month, date of delivery, hospital reg no., ANC no.			
Are the services given for HCT filled for all clients? Check the pre- test counseling, acceptance of HIV test, HIV test result, post-test counseling, received result and infant feeding counseling are documented			
Is the field for ARV therapy filled for all clients? Check that past and/current therapy and date are documented			
TOTAL			