

Referral Date: _____

Client Name: _____



Referral Form Part 1: Case Manager Referral

Referring Agency Information

Referring Agency: _____
Agency Name *Case Manager's Name*

Address: _____
Street Address *Suite #*

_____ _____ _____
City *State* *ZIP Code*

Office Phone: _____ Alternate Phone: _____

E-mail: _____ Fax Number: _____

Client Information

Client's Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ _____ _____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

SS # or GOVT ID: _____ Birthdate/ Age: _____

<p>Marital Status:</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Separated</p>	<p>Identify My Gender As:</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Transgender *</p> <p>_____</p> <p>(fill in the blank)</p>	<p>Race:</p> <p><input type="checkbox"/> White (Non-Hispanic)</p> <p><input type="checkbox"/> African American (Non-Hisp.)</p> <p><input type="checkbox"/> African American (Hispanic)</p> <p><input type="checkbox"/> Hispanic/ Latino (a)</p> <p><input type="checkbox"/> Asian/ Pacific Islander</p> <p><input type="checkbox"/> Native American</p> <p><input type="checkbox"/></p> <p>_____</p> <p>(fill in the blank)</p>
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Insurance Information

Medicaid Provider: _____ Policy #: _____

Medicare Provider: _____ Policy #: _____

Private Insurance: _____ Policy/ Group #: _____

Hospital of Choice: _____ Phone #: _____

Physician: _____ Phone #: _____

Health Information

Current Living Situation (Describe):

Physical Conditions/ Abilities (Ambulatory? Need assistance with ADL's?):

Home Care (Who provides care? Have/ need home health or hospice?):

Support System (Describe who is / is not supportive):

Legal Issues

Have the client been convicted of a crime?: No Yes If yes, please explain below:

Has the client spent any time in jail?: No Yes If yes, please explain below:

Is the client currently on probation or parole?: No Yes If yes, please explain below:

Any unresolved or pending charges?: No Yes If yes, please explain below:

Substance Abuse

Does client use alcohol?

No

Yes

Does client use drugs?

No

Yes

Is client addicted? No Yes If yes, explain what type, the amount used and how often:

Has the client ever been in a treatment program for alcohol use? No Yes

If yes, where and how long?

Has the client ever been in a treatment program for drug use? No Yes

If yes, where and how long?

Is client actively using?: No Yes

Is client interested in participating in a recovery program? No Yes

Income

Income Source:

Wage/ Salaries

Food Stamps

Military Disability

SSI

Unemployment

Housing Assistance

Worker's Compensation

Other: _____

Total Monthly Income: _____

Case Manager's general impressions of client's ability to live in a group setting (attach additional sheets, if needed):

Signature of Interviewer: _____ Date: _____

*****PLEASE ATTACH COMPLETED RYAN WHITE PART A ELIGIBILITY VERIFICATION FORM (CERV) AND PHYSICIAN REFERRAL FORM.**

Referral Form Part 2: Pllysidaru Referral

Physician Information

Referring Agency: _____
Agency Name Primary Physician Name/ ID

Address: _____
Street Address Suite#

_____ City State ZJP Code

Office Phone: _____ Alternate Phone: _____

E-mail: _____ Fax Number: _____

Client Health Information

Full Name: _____
Last First M.J.

Medical Record #: _____ Date of Birth: _____

Date of HIV DX: _____ Date of AIDS DX: _____
 Viral Load/Date (must be within the last 6 months): _____ CD4 CounU Date (Must be within the Last 6 Months): _____

<p>Opportunistic Infections/ Illnesses:</p> <p><input type="checkbox"/> Hepatitis A, B or C</p> <p>Tuberculosis Negative: <input type="checkbox"/> Positive: <input type="checkbox"/> Date of Last Test: _____</p> <p><input type="checkbox"/> Oral Health Issues</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cardiovascular Health</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Wasting Syndrome</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Pneumonia, recurrent</p> <p><input type="checkbox"/> STD/STI</p> <p><input type="checkbox"/> Open Wounds or Sores</p>	<p>Physical Abilities:</p> <p><input checked="" type="checkbox"/> Client Needs Assistance with activities of daily living (ADLs).</p> <p>Height: _____</p> <p>Weight: _____</p> <p>Other Assistance Needed:</p> <p><input type="checkbox"/> Client needs assistance with reading medical forms.</p> <p><input type="checkbox"/> Client has dietary restrictions. Please explain: _____</p> <hr/> <p><input checked="" type="checkbox"/> Other Please explain: _____</p>	<p>Mental Health:</p> <p>Does the client have a documented psych history?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p> <p>If yes, who is the psychiatrist on record?</p> <p>Name: _____</p> <hr/> <p>Phone#: _____</p> <hr/> <p><input type="checkbox"/> Substance Abuse History</p> <p><input type="checkbox"/> Suicidal ideations?</p> <p><input type="checkbox"/> Violent Episodes</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Documented Mental Health Conditions:</p>
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Client Name: _____

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Medications

Is the client allergic to any medications? No Yes If yes, please list in box here:

List of Medications Client Currently Takes	Dosage	List of Medications Currently Takes	Dosage

Additional Comments

Physician's Signature: _____ Date: _____

Physician's Name
(Please print clearly): _____

Client Name: _____
