

PROJECT AIDS CARE
PHYSICIAN REFERRAL and REQUEST for LEVEL OF CARE DETERMINATION

(Clients Diverted from Hospitals)

Incomplete forms will be returned. Please complete all items. If non-applicable please indicate with N/A. Attach extra sheets or supporting documentation if necessary.

Client's Name: _____ SSN# _____ DOB _____

1. AIDS Diagnosis (initial, if yes) _____ (Please indicate Opportunistic infections on reverse side of form)
2. CD4 count _____ % _____ Viral Load _____ as of _____ (Date)
(Percentage) (Absolute)

Defining AIDS without opportunistic infection:..... CD4 Absolute count of less than 200 OR
CD4 Percentage of less than 14

3. Medications (please list all prescribed medications): .

4. All body systems have been reviewed and specific physical findings are checked below.

| | | | |
|------------------------|---------------------------------|--|---|
| ___ Vision and Hearing | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |
| ___ Respiratory | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |
| ___ Gastrointestinal | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |
| ___ Genito-Urinary | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |
| ___ Cardiovascular | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> serious Impairment |
| ___ Musculoskeletal | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |
| ___ Neurological | <input type="checkbox"/> Normal | <input type="checkbox"/> Moderate Impairment | <input type="checkbox"/> Serious Impairment |

5. Medical History Significant to Home Based Care: _____

6. Treatment & therapies: Please check all that apply.

___ Physical Therapy ___ Occupational Therapy ___ Respiratory Therapy
___ Substance Abuse Treatment ___ Massage Therapy ___ Other _____

7. Diet: _____

8. Prognosis: ___ Good ___ Poor ___ Fair Rehabilitation Potential: ___ Good ___ Poor ___ Fair

9. Unmet Home based care needs: _____

OPPORTUNISTIC INFECTIONS

BACTERIAL INFECTIONS

- Mycobacterial infections
- Nocardiosis
- Salmonella Bacteremia
- Syphilis or Neurosyphilis
- Multiple Bacterial Infections

FUNGAL INFECTIONS

- Aspergillosis
- Candidiasis
- Coccidioidomycosis
- Cryptococcosis
- Histoplasmosis
- Mucormycosis'

VIRAL INFECTIONS

- Cytomegalovirus Disease
- Herpes Simplex-Mucocutaneous
- Herpes Zoster
- Progressive Multifocal Leukoencephalopathy
- Hepatitis

PROTOZOAN OR HELMINTHIC INFECTIONS

- Cryptosporidiosis
- Isosporiasis
- Microsporidiosis
- Pneumocystis Carinii
- Pneumonia
- Extrapulmonary Carinii Infection
- Stongyloidiasis, Extra-Intestinal
- Toxoplasmosis

MALIGNANT NEOPLASMS

- Cervical Cancer, Stage II+
- Kaposi's Sarcoma with Wide-spread Involvement
- Lymphoma
- Squamous Cell Carcinoma of the Anus

OTHER COMPLICATIONS

- HIV Wasting Syndrome
- Chronic Diarrhea
- Chronic Weakness
- Cardiomyopathy
- Nephropathy
- Sepsis
- Meningitis
- Pneumonia
- Endocarditis
- Septic Arthritis
- Peripheral Neuropathy
- HIV Encephalopathy/ Dementia

HEMATOLOGIC DISORDERS

- Anemia
- Granulocytopenia
- Thrombocytopenia

10. Other: Repeated manifestations of HIV infection resulting in significant, documented symptoms of one or more of the following:

Restrictions in activities of daily living (Check all that apply):

Ambulation Transfer Skills Eating Skills Dressing Skills Personal Hygiene Skills

Specify other ADL restrictions: _____

Restrictions in Maintaining Social Functioning (Inability to interact appropriately and communicate effectively with others.

Difficulties in Completing and Maintaining Tasks in a Timely Manner Due to Deficiencies in Concentration, Persistence, or Pace (Cannot perform these activities due to fatigue or effects of medication on concentration and coordination.

Specify other mental or physical limitations: _____

11. Do you believe the client is a danger to self and/or others? YES NO

Comments: _____

12. Based on the patient's medical history and current condition, I certify that this individual is disabled and I believe there is reasonable indication that this individual might require hospitalization in the absence of home and community based services provided through a Medicaid waiver program.

Effective Date of Level of Care "At Risk of Hospitalization" _____

13. Physician signature: _____

Physician's name: _____ Date: _____

Address: _____ Telephone: _____