

Client Contact Information – Section A							
First Name:		Last Name		DOB:			
SS#:		MediPass #:		Recipient ID#:			
AHCA Address:							
City:		Zip:		County:			
Primary Address:							
City:		Zip:		County:			
Mailing Address:							
City:		Zip:					
Home Phone:		Cell Phone:		Pager:			
Work Phone:		FAX:		E-Mail:			
AHCA Supplied Address Correct: <input type="checkbox"/> YES <input type="checkbox"/> NO			AHCA Correction Sent: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date:		
Alternative Contact/ Healthcare Consent Information – Section B							
Emergency Contact Person:				Relationship:			
Address:				City/State/Zip			
Aware of HIV Status: <input type="checkbox"/> YES <input type="checkbox"/> NO			Phone:				
Advance Directive Information Supplied: <input type="checkbox"/> YES <input type="checkbox"/> NO			Comment:				
Durable Power of Attorney for Healthcare: <input type="checkbox"/> YES <input type="checkbox"/> NO			Living Will: <input type="checkbox"/> YES <input type="checkbox"/> NO				
Designated Person:				Relationship:			
Address:				City/State/Zip			
Aware of HIV Status: <input type="checkbox"/> YES <input type="checkbox"/> NO			Phone:				
Physician has a copy: <input type="checkbox"/> YES <input type="checkbox"/> NO							
Client Demographic Information – Section C							
<input checked="" type="checkbox"/>	Marital Status	<input checked="" type="checkbox"/>	Race	<input checked="" type="checkbox"/>	Gender	<input checked="" type="checkbox"/>	Housing
	Single		Caucasian		Male		Alone
	Married		African American		Female		With Spouse
	Widowed		Haitian		Transgender M>F		Spouse and Children
	Separated		Hispanic		Transgender F>M		Blood relative
	Divorced		Native American	<input checked="" type="checkbox"/>	Sexual Orientation		Domestic Partner
	Domestic Partner		Pacific Islander		Heterosexual		Group Home
	Other:		Asian		Bisexual		Shelter
<input checked="" type="checkbox"/>	Dependents		Other:		Gay		Homeless
	Children	<input checked="" type="checkbox"/>	Primary Language		Lesbian		Skilled Nursing Facility
	Age: _____ Sex: _____		English	<input checked="" type="checkbox"/>	Risk Category		Shared/Roommate
	Age: _____ Sex: _____		Spanish		Decline to state	<input checked="" type="checkbox"/>	Education
	Age: _____ Sex: _____		Creole		Transfusion		None
	Age: _____ Sex: _____		French		Hemophiliac		K-6th
	Age: _____ Sex: _____		Other:		IVDU		7-12
	Mother	<input checked="" type="checkbox"/>	Written Materials		MSM		Some College
	Father		English		MSM/IVDU		College Graduate
	Sibling		Primary Language		Sex Worker		Post Graduate
	Domestic Partner		Braille		Mother/Child Transmission	<input checked="" type="checkbox"/>	Income
	Other		Non-Reader		Heterosexual		None
<input checked="" type="checkbox"/>	Support System	<input checked="" type="checkbox"/>	Mailings	<input checked="" type="checkbox"/>	Safer Sex		<\$10,000
	Family		All materials OK		Condoms Always		>\$10K <\$20K
	Friends		Thrive Only		Condoms Mostly		>\$20K <\$30K
	Church		Education/PHC		Condoms Sometimes		>\$30K <\$40K
	ASO:		No Mail		Condoms Never		Other

Social Demographics

EMPLOYMENT INFORMATION – Section D			
Occupation:		Employed: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CASH	
Employer:		Hours Worked per week:	
Address		Phone	
City	County	Zip	
Health Benefits: <input type="checkbox"/> YES <input type="checkbox"/> NO		Commercial Health Plan:	
Disabled: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date Disabled:	Applied for SSDI: <input type="checkbox"/> YES <input type="checkbox"/> NO

LIVING ENVIRONMENT – Section E						
<input checked="" type="checkbox"/>	Dwelling	<input checked="" type="checkbox"/>	Dwelling	Number of persons in the household:		
<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> HOPWA <input type="checkbox"/> Other				Question	Yes	No
	Single family dwelling		Rehab Center	Do other household members know HIV Status?		
	Condominium		ACLF	Who:		
	Apartment		Hotel	Other in home HIV Positive?		
	Room			Who:		
	Shelter			Caregiver available if necessary		
	Nursing Facility			Who:		
<input checked="" type="checkbox"/>	Pets			Relationship:		Phone
	Dog #	<input checked="" type="checkbox"/>	Utilities	<input checked="" type="checkbox"/>	Appliance	<input checked="" type="checkbox"/>
	Cat #		Running Water		Stove	Car
	Bird #		Electricity		Refrigerator	Family/Friends
	Reptile #		Gas		Air Cond	Bus
	Other &#		Phone		Microwave	Other
Who Cleans up:						Other
Home Communication Media: (Equipment for education materials)			VCR		DVD	Cassette Player
			CD Player			Computer

SOCIAL SERVICE/ANCILLARY HEALTH PROVIDERS – Section F			
ASO Name:		Phone:	
Address:			
City	County	Zip	
ASO Case Manager:			
ASO CM Phone:	ASO CM e-mail:	ASO CM Other:	

PAC Waiver Services – Section G					
	Adult Dental		Homemaker		Specialized Care Foster Child
	Case Management		Nutritional Risk Reduction		Other
	Chore – Pest Control		Personal Care		Other
	Chore - Other		Skilled Nursing – RN/LPN		
	Day Health Care		Specialized Medical Equipment		
	Education and Support		Medical Supplies		
	Environmental Adaptations		Therapeutic Mgmt Substance		
	Home Delivered Meals		Restorative Massage		

Assistance Benefits – Section H					
	Cash Assistance		OSS		Private disability
	SSI		Unemployment		ADAP
	Medicaid		Medicare		Veterans Medical
	Indian Medical Services		Food Stamps		Veterans Pension
	Private Retirement		Life Insurance		Insur. Continuation (ICAP)

Assistance Benefits Detail – Section I			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			

Mental Health/Life Habits Information – Section J			
Are you currently seeing a mental health provider?		YES:	NO:
Type of provider: <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> LCSW <input type="checkbox"/> MFCC <input type="checkbox"/> MSW <input type="checkbox"/> Group <input type="checkbox"/> Other:			
Provider Name:		Phone	
Address:		City:	Zip
E-mail:		Access to Chart: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Symptoms			
Are you currently experiencing any of the following: (check if present)			Increased sadness?
<input type="checkbox"/> Increased tearfulness?	<input type="checkbox"/>	<input type="checkbox"/> Sleep disturbance?	<input type="checkbox"/> Feeling of helplessness/hopelessness
<input type="checkbox"/> Decrease sex drive?	<input type="checkbox"/>	<input type="checkbox"/> Loss/decrease energy?	<input type="checkbox"/> Loss of interest in usual/favored activities
<input type="checkbox"/> Low self esteem?	<input type="checkbox"/>	<input type="checkbox"/> Difficulty concentrating?	<input type="checkbox"/> Feelings of guilt?
If client is experiencing 5 or more of these symptoms, he/she may be depressed. Contact PCP for Mental Health referral.			



✓ Current Therapy For –Section K							
	Anxiety		Bipolar	Substance Abuse			
	Depression		Panic Disorder	OCD			
	Grief		Schizophrenia	Other:			
Comment:							
Exercise – Section L							
✓	Exercise Routine	Frequency		Duration			
	None						
	Walking						
	Bike Riding						
	Aerobic						
	Weight Training						
	Swimming						
	Jogging						
	Calisthenics						
	Other:						
	Other:						
Diet and Nutrition - Section M							
Current Weight:		Height:		Ideal Body Weight:			
Recent Weight Loss/Gain: <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount Loss/Gain:		Period of time:			
Intentional Loss/Gain: <input type="checkbox"/> Yes <input type="checkbox"/> No		Comment:					
Body Fat/Bone Density Measurement – Section N							
"	Waist	"	R Upper Arm	"	Abdomen	"	R Thigh
"	Hips	"	L Upper Arm	"		"	Facial Wasting
"	Chest	"	L Thigh	"		"	“Buffalo Hump”
BIA Done: <input type="checkbox"/> Yes <input type="checkbox"/> No		BIA Result:			Date BIA Done:		
Bone Density Done: <input type="checkbox"/> Yes <input type="checkbox"/> No		BD Result:			Date BD Done:		
Diet – Section O							
Special Diet: <input type="checkbox"/> Yes <input type="checkbox"/> No				Diet Type:			
Restrictions:							
Supplements Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No				Supplement Type:			
Vitamins/Minerals Taken:				Frequency:			
Vitamins/Minerals Taken:				Frequency:			
Vitamins/Minerals Taken:				Frequency:			
Herbals Taken:				Frequency:			
Herbals Taken:				Frequency:			
Herbals Taken:				Frequency:			
Food Allergies:							
Usual Water per day: <input type="checkbox"/> 1-3 glasses <input type="checkbox"/> 4 – 6 glasses <input type="checkbox"/> 7- 9 glasses <input type="checkbox"/> 10 – 12 glasses <input type="checkbox"/> None							
Comments:							

PHC INITIAL ASSESSMENT

Patient Name: _____
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Nurse: _____ Pt. I.D. Number: _____



Medical/Ancillary Health Provider Information – Section Q			
MediPass Primary Care Provider			
Primary Care Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Specialty:	Medical Group Name:		
Currently Seeing MediPass PCP: <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Attending Provider			
“Attending Provider”			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Specialty:	Medical Group Name:		
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Specialty Medical Provider(s)			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Specialty:	Medical Group Name:		
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:		Access to Medical Record: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Additional Medical Provider			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Specialty:	Medical Group Name:		
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Dental Care Provider			
Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO	Last Visit:		Reason:
Frequency of visits:			
Comment:		Access to Medical Record: <input type="checkbox"/> YES <input type="checkbox"/> NO	

PHC INITIAL ASSESSMENT

Patient Name: _____
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Nurse: _____ Pt. I.D. Number: _____



Medical/Ancillary Health Provider Information – Section Q Continued

Ancillary Health Provider

Name:			
Type: <input type="checkbox"/> Home Health Skilled Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Other:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing: <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:		Access to Medical Record: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Ancillary Health Provider

Name:			
Type: <input type="checkbox"/> Home Health Skilled Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Other:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	
Reason for Last Visit:			
Comment:		Access to Medical Record: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Pharmacy

Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Fill:	
Refills all on same schedule: <input type="checkbox"/> YES <input type="checkbox"/> NO		Do you call for Refills?: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Are Refills Done Automatically by Pharmacy: <input type="checkbox"/> YES <input type="checkbox"/> NO		Pharmacist Name:	
Access to Pharmacy Profile: <input type="checkbox"/> YES <input type="checkbox"/> NO Comment:			
Payer Source: <input type="checkbox"/> Medicaid <input type="checkbox"/> ADAP <input type="checkbox"/> Veterans <input type="checkbox"/> Indian Affairs <input type="checkbox"/> Private Plan <input type="checkbox"/> Cash <input type="checkbox"/> Other			
Comment:			

Additional Pharmacy

Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Fill:	
Refills all on same schedule: <input type="checkbox"/> YES <input type="checkbox"/> NO		Do you call for Refills?: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Are Refills Done Automatically by Pharmacy: <input type="checkbox"/> YES <input type="checkbox"/> NO		Pharmacist Name:	
Access to Pharmacy Profile: <input type="checkbox"/> YES <input type="checkbox"/> NO Comment:			
Payer Source: <input type="checkbox"/> Medicaid <input type="checkbox"/> ADAP <input type="checkbox"/> Veterans <input type="checkbox"/> Indian Affairs <input type="checkbox"/> Private Plan <input type="checkbox"/> Cash <input type="checkbox"/> Other			
Comment:			

Other Ancillary Health Provider

Name:		Type:	
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : <input type="checkbox"/> YES <input type="checkbox"/> NO		Last Visit:	Reason:
Comment:		Access to Medical Record: <input type="checkbox"/> YES <input type="checkbox"/> NO	



MEDICAL HISTORY – Section R

ALLERGIES:

HIV History

First HIV Positive Date:	Source: <input type="checkbox"/> Client Self Report <input type="checkbox"/> Medical Record		
Most Recent Viral Load Date:	Result:	Most Recent CD4 Date:	Result:
Highest VL Date:	Result:	Lowest CD4 Date:	Result:

Source = C (Chart) P (Patient Reports) Opportunistic Diseases and/or Complications

Source	Onset ✓	Resolved ✓	Condition	Source	Onset ✓	Resolved ✓	Condition
			Pneumocystis carinii pneumonia (PCP)				HIV Encephalopathy
			Esophageal Candidiasis				Other neuro manifestations, eg. Peripheral neuropathy
			Kaposi's Sarcoma				Cardiomyopathy (CHF or cor pulmonale or other abn. Not responsive to treatment)
			HIV wasting disease (>10% wt loss)				Nephropathy resulting in chronic renal failure
			Mycobacterium avium complex (MAC)				Infections resistant to treatment/requiring hospitalization or IV's 3x/year (e.g. sepsis, meningitis, pneumonia, septic arthritis, endocarditis, sinusitis)
			Cytomegalovirus disease (eyes)				Anemia (Hct @30% or <
			Cytomegalovirus disease (GI)				Granulocytopenia ANC < 1000
			Cytomegalovirus disease (Disseminated)				recurrent bacterial infection 3x in 5 mo
			AIDS Dementia Complex				Cancer of Cervix, invasive FIGO Stage II and >
			Cryptococcosis				Thrombocytopenia Platelets<40K repeatedly with spontaneous bleed
			Non-Hodgkin's lymphoma				Diarrhea lasting > 1 mo, resistant to treatment
			Toxoplasmosis				Cholesterol abnormalities
			Cryptosporidiosis				Triglyceride abnormalities
			Chronic herpes simplex infection				Diabetes
			Recurrent bacterial pneumonia				Insulin resistance
			Tuberculosis				Fat Maldistribution
			Multiple vaginal infections				Osteoporosis
			PML				Osteopenia
			Cholesterol abnormalities				Osteomalacia
			Aspergillosis				Lactic Acidosis
			Histoplasmosis				Pancreatitis
			Isosporiasis				Microsporidiosis
			Other:				Strongyloidiasis (extra-intestinal)
							Other:

CDC AIDS Case Definition Categories

✓	CD4 Cell Categories	✓	A: Asymptomatic or PGL or Acute HIV Infection	✓	B: Symptomatic (not A or C)	✓	C: AIDS Indicator Condition
	1. > 500/mm ³ (29%)		A1		B1		C1
	2. 200 to 499/ mm ³ (14% to 28%)		A2		B2		C2
	3. <200/ mm ³ (14%)		A3		B3		C3

*** All patients in categories A3, B3, and C1-3 are defined as having AIDS based on the presence of an AIDS indicator condition and/or a CD4 cell count < 200/mm³**

ARV THERAPY HISTORY

Currently taking ARV Regimen: YES NO **IF NO, WHY?:** Refused CD4> 500
 CD4 > 350, VL < 55,000(PCR) or <33,000 (b DNA) Other:

PHC INITIAL ASSESSMENT

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ARV THERAPY HISTORY								
Pt. Taking	Pharm Filling	Start	Stop	NRTIs		Dose	Frequency	DC Reason
				Zidovudine	Retrovir (AZT)			
				Didanosine	Videx (ddI)			
				Zalcitabine	Hivid (ddC)			
				Stavudine	Zerit (d4T)			
				Lamivudine	Epivir (3TC)			
				Abacavir	Ziagen (ABC)			
				Combivir	AZT + 3TC			
				Trizivir	AZT+3TC+ABC			
Pt. Taking	Pharm Filling	Start	Stop	NNRTIs		Dose	Frequency	DC Reason
				Nevirapine	Viramune (NVP)			
				Delavirdine	Rescriptor (DLV)			
				Efavirenz	Sustiva (EFV)			
Pt. Taking	Pharm Filling	Start	Stop	PROTEASE INHIBITORS		Dose	Frequency	DC Reason
				Indinavir	Crixivan (IDV)			
				Ritonavir	Norvir (RTV)			
				Saquinavir	Invirase, Fortovase (SQV)			
				Nelfinavir	Viracept (NFV)			
				Amprenavir	Agenerase (APV)			
				Lopinavir/ritonavir	Kaletra (ABT/378/R, LPV/RTV)			
Pt. Taking	Pharm Filling	Start	Stop	INVESTIGATIONAL DRUGS		Dose	Frequency	DC Reason
				NRTI	Emtricitabine	200mg	QD	
				NRTI	DAPD	300-500 mg	BID	
				NRTI	Tenofovir	300mg	QD	
				NNRTI	Capravirine	700-1200 mg	BID	
				NNRTI	TMC120	50-100 mg	BID	
				PI	BMS-232632	200-500 mg	QD	
				PI	Tipranavir	300-1200mg + 200mg Ritonavir		
				BFI*	T-20	50-100 mg	BID	
				BFI*	T-1249	6.25-50 mg	QD or BID	
				BFI*	PRO 542	0.2 10.0 mg/kg IV		

* BFI = Binding/ Fusion Inhibitors

PRIMARY INVESTIGATOR IF ON INVESTIGATIONAL DRUGS	
P.I. Name:	
Study:	
Study Location:	
Study Coordinator:	Phone:

PROPHYLACTIC MEDICATIONS				
Start	Stop	Medication	Recommendations	Disease Prevention
		TMP/SMX 1DS/day or 1 SS/day or 3DS/week	<200-250 CD4	PCP
		Fluconazole 100-200mg/day PO	High risk pt with <50 CD4	Crypto, Coccidio
		TMP/SMX 1 DS/day PO	+ Toxo IgG with CD4<100	Toxoplasmosis
		Cytovene 1 g PO tid	<50 CD4	CMV
		Clarithromycin 500 mg qd or bid	<50 CD4	MAC

PHC INITIAL ASSESSMENT

Patient Name: _____
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Nurse: _____ Pt. I.D. Number: _____



GYN HISTORY – Section T			
LMP:	Gravida:	Para:	Births since HIV+:
HIV + Children:		Desire Children:	
Last PAP Smear Date:		Results:	
Birth Control Method: <input type="checkbox"/> Rhythm Method <input type="checkbox"/> Barrier <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Abstinence <input type="checkbox"/> Other:			
Menopause Onset Date:		Estrogen Replacement:	

IMMUNIZATION HISTORY – Section U			
Date	Immunization	Date	Immunization
	Dip Tet		Pneumococcal CD4 when given:
	MMR		Influenza
	Polio		Varicella
	Hepatitis B		Other:
	Hepatitis A		Other:

SUBSTANCE USE HISTORY – Section V				
✓	Substance	Amount	Frequency	✓ if currently using
	Alcohol*			
	Opiates			
	Marijuana			
	Cocaine/Crack			
	Speed/Amphetamines			
	PCP			
	GHB			
	Ecstasy*			
	Methadone			
	Fentanyl Patch			
	OxyContin			
	Crystal Meth			
	“Special K” *			
	Other:			

* Significant drug/drug interaction with PIs.

If actively using, is client interested in stopping? YES NO

LIVER DISEASE HISTORY – Section W				
Hepatitis B				
Have you had Hepatitis B: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN If YES DATE DIAGNOSED:				
Test	Date	Result Positive ✓ / Negative ✓	Source of Info Chart ✓ / Patient ✓	
Anti-HBc (Hepatitis B Core Antibody)				
Anti-HBs (Hepatitis B Surface Antibody)**				
HBsAg (Hepatitis B Surface Antigen)				

** If recently vaccinated, Anti-HBs needs to be done 1 to 6 months after the last dose of vaccine.

Hepatitis B Vaccine					
Date Given	Vaccine	Date Due	Date Given	Vaccine	Date Due
	Hepatitis B Vaccine 1cc dose #1			Hepatitis B 1cc dose #3	
	Hepatitis B Vaccine 1 cc dose #2			HbsAb Test to verify	

Hepatitis B Treatment History				
Start Date	Stop Date	Treatment	Result	Source of Info Chart ✓ / Patient ✓
		Epivir 150 mg bid (HIV) or 100mg/day (HBV)		
		Interferon 30-35 mil units/wk x 4 mo		
		HARRT therapy with no anti-HBV agents		
		Nothing		
		Other:		
		Epivir+ famciclovir 500mg bid or tid to decrease resistance to Epivir. (<i>Experimental</i>)		

Hepatitis C				
Do you have Hepatitis C: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN If YES DATE DIAGNOSED:				
Test	Date	Approximate \$	Result Positive ✓ / Negative ✓	Source of Info Chart ✓ / Patient ✓
EIA for Anti-HCV		25 – 45		
RIBA for Anti-HCV		115 – 150		
RT-PCR for HCV RNA		160 – 200		
HCV PCR (Quantitative RNA)		160 – 225		
Genotype		200 – 250		

Hepatitis C Treatment History				
Start Date	Stop Date	Treatment	Result	Source of Info Chart ✓ Patient ✓
		Hepatitis A vaccine if HAV sero-negative		
		Alpha interferon, 3 million units SC 3x/wk plus Ribavirin 1000 – 1200 mg/day PO x 24 wks for genotype 2&3 or 48 wks for genotype 1		
		Peginterferon alfa 2, or alpha 2b (PEG-Intron), 1.0-1.2 mg/kg q wk SC; both should be combined with ribavirin 10.6 mg/kg/day x 48 weeks		
		Nothing		
		Other:		

Hepatitis A				
Have you had Hepatitis A: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN If YES DATE DIAGNOSED:				
Test	Date	Result Positive ✓ / Negative ✓	Source of Info Chart ✓ / Patient ✓	
Anti-HAV (IgG)				

Hepatitis A Prophylaxis History			
Date Given	Treatment	Chart ✓	Patient ✓
	Havrix 0.5 mL IM x 2 separated by 6 months		
	Havrix 0.5 mL IM second dose		

PAIN HISTORY – Section X						
Question	Yes	No	✓	Pain Characteristics	✓	Pain Characteristics
Do you currently have pain?				Constant		Dull, aching
Pain Scale	#			Intermittent		Burning
Scale of 1-10, 10 being worst:				Sharp		Tingling
Location of Pain:				Stabbing		Numbness

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PAIN MEDICATIONS				
✓	Medication	Dose	Frequency	Effective ✓
	ASA, Acetaminophen			
	Codeine			
	Demerol			
	Dilaudid			
	Methadone			
	MS Contin			
	OxyContin			
	Fentanyl Patch			
	Ultram			
	NSAIDS			
	Neurontin			
	Lortab:			
	Vicodin:			
	Other:			
	Other:			

Sexually Transmitted Diseases – Section Y							
Onset	Treated	Resolved	Infection	Onset	Treated	Resolved	Infection
			Syphilis				Chancroid
			Gonorrhea				Herpes
			LGV (Lymphogranuloma venerium)				Rectal Warts
			HPV (Genital Warts)				Trichomonas
			Condyloma				Other
			Chlamydia				Other
STD Comments:							

Prosthesis and/or Implanted Devices							
✓	✓	✓	✓	✓	✓	✓	✓
	Hearing Aid		PortaCath		Pacemaker		
	Glasses		Triple lumen catheter				
	Dentures		PICC line				

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									Write in Lab Name on this line
Test	Date	Result	Date	Result	Date	Result	Date	Result	Recommend Frequency
HIV Ab									Initial
CD4 Absolute									Q 3 to 6 MONTHS
CD4 %									Q 3 to 6 MONTHS
Viral Load									Q 3 to 6 MONTHS
Hemoglobin									Q 3 to 6 MONTHS
Hematocrit									Q 3 to 6 MONTHS

PHC INITIAL ASSESSMENT

Patient Name: _____
 AHF/FPHC © 06/2002

Nurse: _____ Pt. I.D. Number: _____



LABORATORY RESULTS – Section Z

(Record the most recent test available and the date done)

Lab Name:									Write in Lab Name on this line
Test	Date	Result	Date	Result	Date	Result	Date	Result	Recommend Frequency
WBC									Q 3 to 6 MONTHS
RBC									Q 3 to 6 MONTHS
Platelets									Q 3 to 6 MONTHS
ANC									Q 3 to 6 MONTHS
K									Initial and PRN as appropriate
Na									Initial and PRN as appropriate
Cl									Initial and PRN as appropriate
CO2									Initial and PRN as appropriate
FBS									2 mo. After starting PI and q 3 to 4 months
BUN									
Creatinine									
Bilirubin									
AST									Base & 24 wks after initiation of tx
ALT									Base & 24 wks after initiation of tx
Albumin									Base & 24 wks after initiation of tx
Alk Phos									Base & 24 wks after initiation of tx
GGT									Base & 24 wks after initiation of tx
Lipase									Per Symptoms
Amylase									Per symptoms
Lactic Acid									Per Symptoms
VDRL/RPR									Q Year or PRN by history
LDH									Per Symptoms
CPK									Per Symptoms
Cholesterol									Base and Q 3 to 6 Mo

PHC INITIAL ASSESSMENT

Patient Name: _____ Pt. I.D. Number: _____
 AHF/FPHC © 06/2002 Nurse: _____ Page 14 of 15



Acuity Determination Tool

Social Demographic Findings from Assessment	0	1	2	3	Comment
Marital Status					
Single					
Married					
Widowed					
Separated					
Divorced					
Domestic partner					
Dependents (Select only 1 answer)					
No Dependents					
Children over 18					
Children > 5 years at home					
Children < 5 years at home					
Support System (Select those that apply)					
Alone - no friends or family					
Lives alone some friends					
Lives alone family close by					
Lives with friends/family--no support					
Lives with friends/family--adequate support					
Others in the home Do Not know of HIV status					
Housing (Select only 1 answer)					
Lives alone apartment or house					
Lives with others--permanent					
Lives with others--temporary					
Lives at a shelter					
Lives in a supervised facility					
Homeless					
Utilities (Select all that apply)					
No Phone					
No Water					
No Gas--if needed for cooking or hot water					
No electricity					
Appliances (Stove/Refrigerator)					
Missing stove					
Missing refrigerator/freezer					
Transportation (Select only 1 answer)					
Dependant on Bus/Taxi					
Has own transportation					
Has third party funded transportation					
Has access to transportation--family/friend					
Unable to Access Public Transportation					

Client Name: _____

RNCM: _____

ID#: _____

Date: _____

Acuity Determination Tool

Social Demographic Findings from Assessment	0	1	2	3	Comment
Income					
None					
<10K income and or benefits					
10K--20K income and benefits					
>20K in income and benefits					
Employment (Select all that apply)					
Employed (Part-time or Full-time)					
Unemployed					
Disabled					
Benefits (Select only 1 answer)					
No benefits					
1--2 benefits					
3--6 benefits					
> 6 benefits					
Education (Select all that apply)					
None					
K-6					
7-12					
> 12 years of school					
reads and writes English					
reads and writes another language					
does not read or write any language					
No Mailings					
Language (Select only 1 answer)					
Primary language is English					
English as a second language (ESL)					
Does not speak English					
Mental Health Risk					
Exhibits mental health challenges--not in care					
Exhibits mental health challenges--in care					
No mental health issues apparent					
Refuses mental health care					
Health Risk Behaviors (Select all that apply)					
Overweight					
Active substance abuse					
Non-Adherence to Treatment Regimen					
ETOH abuse					
Smoking tobacco and/or chewing tobacco					
	No			Yes	
Practices unsafe sex					

Client Name: _____

RNCM: _____

ID#: _____

Date: _____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
<i>Diet and Nutrition</i>						
	Weight appropriate for height					
	< 90% of Ideal Body Weight					
	> 10% Unintentional Weight Loss					
<i>CD4 & Viral Load</i>						
	CD4 > 500					
	CD4 499 - 350					
	CD4 349 - 51					
	CD4 < 50					
<i>Viral Load</i>						
	Undetectable					
	51 - 10,000					
	10,001 - 19,999					
	> 20,000					
<i>Absence of Antiretroviral Therapy (1 answer only)</i>						
	CD4 < 350 regardless of VL					
	CD4 350 - 500 & VL >5,000					
	CD4 > 500 & VL >30,000					
<i>Past and Present Medical History</i>						
	Hospitalizations, OI's and Co-Morbid conditions--1 pt each					
	Cancer--in the past					
Pain	0-2					
	3-5					
	6-8					
	9-10					
<i>Current Medication Regimen</i>						
	Currently not prescribed any medications					
	Currently taking antiretrovirals only					
	Taking both antiretrovirals and other meds					
	Taking other medication (Non ARV)					

Client Name: _____

RNCM: _____

ID#: _____

Date: _____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
Activities of Daily Living						
<i>(Select the most appropriate answer)</i>		Independent	Minimal Assist	Max Assist	Dependent	
Personal Hygiene						
bathing						
oral hygiene						
toileting						
grooming						
dressing						
Nutritional Status						
grocery shopping						
cooking						
feed self						
Activity						
ambulate (walking)						
transfers (if using devices)						
driving						
use public transportation						
clean home						
child care						
pay bills						
can use phone						
fill out forms						
medication administration						
medical testing--BGM or BP						
medical treatment--dressings						
Sense impairment		No	Yes			
Sight						
Hearing						
Reading						
Speech						

Scoring Methodology	1 - Low	2- Medium	3 - High
	0-24	25-35	>36

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Client Name: _____

RNCM: _____

ID#: _____

Date: _____



Name: Acuity Determination Tool		
Approved By:	Date: September 2002	No:
Director PHC Florida _____ Chief of Managed Care _____	Review Date: May 14, 2004 Revised Date: May 14, 2004	

POLICY:

The Acuity Determination Tool (ADT) will be used in conjunction with the AHF/Positive Healthcare Initial Assessment/Reassessment Tool to assist the RN Care Manager (RNCM) in determining a client’s level of need.

PROCEDURE:

Upon completion of the Initial/Reassessment, the RNCM will:

1. Determine a preliminary acuity based on their clinical judgment.
2. Complete a preliminary acuity form and give it to the PAC Case Manager immediately following the assessment.
3. Enter the assessment within 30 days and provide a computer generated final acuity level which based on the following scores:

0-24 = Severity Level 1
 25-35 = Severity Level 2
 36 or greater = Severity 3

The RNCM has the authority to override the severity level assigned according to scale; the reason must be justified in a progress note and written on the computer generated acuity form.

Project AIDS Care Preliminary Acuity Determination

The preliminary acuity level assigned to this patient is a _____. This is based on a face-to-face medical needs assessment only. The final acuity level is pending a medical record review at the provider's office and a Plan of Care meeting with the primary care provider and other members of the healthcare team, including the case manager.

Once this is complete, you will receive final acuity level determination for your records.

Thank you,

AHF/Positive Healthcare
RN Care Manager

Patient name: _____

Medicaid ID#: _____

Date assessed: _____

