

FOLLOW-UP OF IMMIGRANTS OR REFUGEES WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AFTER RESETTLEMENT

This will satisfy the agreement of the health care provider to document that he/she supplied counseling and any treatment or observation necessary for the proper management of the alien's HIV infection.

NAME OF PATIENT: _____ Date of Birth / /
Mo/ day /yr

Sex _____ Country of Birth _____

Race _____ Ethnicity _____

Date of Patient's first visit / / Date of patient's most recent visit / /
Mo/ day /yr Mo/ day /yr

1. Patient still under your care? Yes No

(a) If no, did you refer to another physician? Yes No

(b) If yes, please give name and address of referring physician.

Name: _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

2. Patient's most recent CD4 count is _____ mm²

OR

patient's most recent range: $\geq 500/\text{mm}^2$ 200 - 499/mm² $\leq 200/\text{mm}^2$

Date / /
Mo/ day /yr

3. Patient's most recent viral load _____ units Date / / (Mo/ day /yr)

4. Patient's symptom profile
- Asymptomatic Yes No
- Mild symptoms Yes No
- Opportunistic infections Yes No

5. Is the patient receiving therapy? Yes No
- If yes, please indicate the kind of therapy below:

| Therapy | Yes | No | Therapy | Yes | No |
|-----------------------------|-----|----|-----------------------|-----|----|
| Zidovudine (AZT) (Retrovir) | | | Nevirapine | | |
| Didanosine (ddl) (Videx) | | | Saquinavir (Invirase) | | |
| Zalcitabine (ddC) (HIVID) | | | Ritonavir (Norvir) | | |
| Lamivudine (3TC) (Epiver) | | | Indinavir (Crixivan) | | |
| Stavudine (d4T) (Zerit) | | | Nelfinavir | | |
| Others, specific: | | | | | |
| Others, specific: | | | | | |

6. Did your patient receive HIV/AIDS counseling? Yes No
- If yes, was the help of an interpreter necessary? Yes No
- If yes, was an interpreter used? Yes No

If yes, go to 7; if no, go to 8

7. Check all the topics of counseling which were provided?

| Topic | Yes | No | Topic | Yes | No |
|-----------------------------------|-----|----|-----------------------------------|-----|----|
| Sexual relationships (condom use) | | | Pregnancy and risks to the unborn | | |
| Not to donor blood | | | Breast eating and risk to newborn | | |
| Not to share needles or syringes | | | Personal care | | |
| Others, specific: | | | | | |
| Others, specific: | | | | | |

Comments: _____

Note: Additional information for healthcare workers on HIV infection and AIDS is available by calling CDC's National Prevention Information Network at 1-800-458-5231 or by visiting the NPIN website at <http://www.cdcnpin.org>. Patients can obtain additional information and

referrals to services available in their area--in English and in Spanish--from CDC's National AIDS Hotline by calling 1-800-342-2437.

8. Name of Physician (print) _____
Signature _____ Date ____ / ____ / ____ (Mo/ day /yr)

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