INTIAL PATIENT INFORMATION FORM INSTRUCTIONS

INTIAL PATIENT INFORMATION FORM INSTRUCTIONS

Patient Project ID: Provide the unique Patient Project ID for whom this form is being completed.

Staff Project ID: Provide the unique Staff Project ID for the staff person completing this form.

Clinic Project ID: Provide the unique Clinic Project ID for the reporting clinic site.

FOR PARTNERED SITE USE ONLY

PATIENT INFORMATION:

ADDRESS: Enter patient's current street number and name, city, state, and zip code.

PHONE NUMBER: Enter the patient's most current telephone number(s). Check the "mobile" box if the number is for the patient's mobile phone. Check the "home" box if the number is for the patient's home phone.

EMAIL ADDRESS: Enter the patient's email address.

CLINIC INFORMATION:

PROVIDER NAME: Enter the first and last name of the provider who is most responsible for the medical management of the patient.

CLINIC NAME: Enter the name of the project clinic.

CLINIC NUMBER: Enter the area code and main phone number of the clinic.

CLINIC FAX NUMBER: Enter the clinic fax number, including area code.

PRIMARY CLINIC CONTACT PERSON: Enter the first and last name of the primary clinic contact person who can be contacted to discuss patient care and supply additional information if needed.

   CONTACT PHONE NUMBER: Enter the area code and telephone number for the primary clinic contact person

   EMAIL ADDRESS: Enter the email address for the primary clinic contact person

SECONDARY CLINIC CONTACT PERSON: Enter the first and last name of the secondary clinic contact person who can be contacted to discuss patient care and supply additional information if needed.

   CONTACT PHONE NUMBER: Enter the area code and telephone number for the secondary clinic contact person

   EMAIL ADDRESS: Enter the email address for the secondary clinic contact person

Attachment 6b

DATE: Enter the date (MM/DD/YYYY) the *Initial Patient Information form* was completed.

I. PATIENT DEMOGRAPHICS

DATE OF BIRTH:
- Enter patient's month (MM) and year (YYYY) of birth.

SEX:
- Select patient's sex
- If patient is transgender, check **"Transgender"** <u>in addition</u> to the patient's sex *at birth*.
  - Transgender is defined as an individual whose physical or birth sex is male or female but whose gender expression and/or identity differ from that which was documented at birth

RACE:
- Select the patient's race.
- Select more than one race if applicable.
- If none of the listed options apply, please check "**other**" and write in the race.
- If the option includes a "/", this implies "or". For example Black/African American is Black *or* African American.

ETHNICITY:
- Select the patient's ethnicity
- If ethnicity is unknown, check **"Unknown".**
- If the option includes a "/", this implies "or". For example Hispanic/Latino is Hispanic or Latino

EDUCATION LEVEL:
- Select the patient's highest education level completed
- If education level is unknown, check **"Unknown".**

NUMBER OF PEOPLE IN HOUSEHOLD:
- Record the number of people living in the patient's household
  - A **household** includes all the people who occupy a housing unit as their usual place of residence. The occupants of a household may be any group of related or unrelated persons who share living arrangements.
- If the number of people living in the patient's household is unknown, check **"Unknown"**

ANNUAL HOUSEHOLD INCOME:
- Select the patient's annual household income
  - **Household income** includes the income of the householder and all other individuals 15 years old and over in the household, whether or not they are related to the householder
- If annual household is unknown, check **"Unknown".**

HOUSING STATUS:
- Select the option that best describes the patient's current housing status.
- If housing status is unknown, check **"Unknown".**

EMPLOYMENT STATUS:
- Select the patient's current employment status
- Select all that apply
- If employment status is unknown, check **"Unknown".**

If patient is employed, is he/she employed part time or full time?
- If patient is unemployed, check **"N/A"**
- If patient is employed, check **"part time"** if the patient is employed less than 32 hours a week or check "**full time**" if the patient is employed 32 hours per week or more.
- If the patient's part time/full time status is unknown, check **"Unknown"**

MEDICAL INSURANCE STATUS:
- Select the patient's medical insurance status.
- Check all that apply
- If no medical insurance status information is available, check **"Unknown".**

Date of patient's first visit to *THIS* clinic: _____/_____/_____ (MM/DD/YYYY)
- Enter date (MM/DD/YYYY) patient was first seen in *THIS* clinic for a visit with a physician, nurse practitioner or physician's assistant.

II. DIAGNOSIS INFORMATION

FOR ALL DATES, if the exact date is not known, provide as much information as possible. For example, if the day is unknown but the month and year are known, provide the month (MM) and year (YYYY).

DATE OF HIV DIAGNOSIS:
- Enter the date (MM/DD/YYYY) the patient first received a confirmed *HIV* diagnosis.
- If no date of HIV diagnosis information is available, check **"Unknown".**

DISEASE STAGE AT DIAGNOSIS:

- **Select the stage of HIV disease at diagnosis:**
  - **Stage 1 HIV:** No AIDS-defining condition and either CD4+ T-lymphocyte count of ≥500 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of ≥29.
  - **Stage 2 HIV:** No AIDS-defining condition and either CD4+ T-lymphocyte count of 200–499 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of 14-28.
  - **Stage 3 HIV (AIDS):** CD4+ T-lymphocyte count of <200 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of <14, or documentation of an AIDS-defining condition. Documentation of an AIDS-defining condition supersedes a CD4+ T-lymphocyte count of ≥200 cells/µL and a CD4+ T-lymphocyte percentage of total lymphocytes of ≥14.
  - **Stage unknown:** No information available on CD4+ T-lymphocyte count or percentage and no information available on AIDS-defining conditions.
  - If the patient's stage of disease at time of diagnosis is not known or unavailable, check **"Unknown".**

DATE FIRST ENTERED INTO CARE FOR HIV:
- Enter the date (MM/DD/YYYY) the patient first entered into care for HIV.
    - o **The date should be the date that the patient first entered in care *ever* for HIV** which might not be the same date as when the patient first entered into care at <u>this</u> clinic.
- If information on when the patient first entered care for HIV is not known or unavailable, check **"Unknown".**

III. <u>PATIENT LABORATORY INFORMATION:</u>

A. **Please provide the following information:**

Height
- Enter the patient's most recent height in inches.
- Enter the date (MM/DD/YYYY) that the height was measured.

Most recent weight (lbs. /kg)
- Enter the patient's most recent weight. Circle if weight was measured in pounds (lbs.) or kilograms (kg).
- Enter the date (MM/DD/YYYY) that the weight was measured.

B. **Please provide blood pressure values for the <u>past 12 months</u>.**

- For all blood pressure values obtained over the <u>past 12 months</u>, enter the patient's blood pressure value (systolic/diastolic) and date (MM/DD/YYYY) the blood pressure was measured.
- Blood pressure values should be recorded with the following units: mmHg

C. **Please provide the following laboratory values for the <u>past 24 months</u>.**

All dates in this section should reflect the date that each lab test was drawn

If there are more than four labs values to be reported use the additional table at the end of the Initial Patient Information form (page xx).

CD4:
- Enter each absolute **CD4** and **% CD4** laboratory test result for the **<u>past 24 months</u>**.
- The absolute **CD4** test results should be recorded with the following units: cells/ μL
- The **% CD4** test result should reflect the percentage of total lymphocytes that are CD4 cells.
- If both the absolute **CD4** count and **% CD4** are available, *record both*. If both are not available, enter the one test result that is available and leave the other blank.
- Enter the date (MM/DD/YYYY) each **CD4** laboratory test was taken.

HIV-1 RNA/DNA NAAT (Quantitative viral load):
- Enter each **HIV-1 RNA or DNA NAAT** quantitative **viral load** test result for the **<u>past 24 months</u>**

- The **viral load** test results should be recorded with the following units: copies/milliliter (mL).
- Enter the date (MM/DD/YYYY) each **viral load** test was taken.
- **Viral load** tests with undetectable results (based on the assay threshold) should also be entered here.
    - o   For example, for results with a value less than 48, record as **<48 copies/mL**.

D.   Please provide the following laboratory values for the <u>past 12 months:</u>

All dates in this section should reflect the date that each lab test was drawn

If there are more than four labs values to be reported use the additional table at the end of the Initial Patient Information form (page xx).

Total cholesterol
- Enter each **total cholesterol** laboratory result for the <u>**past 12 months.**</u>
- The **total** cholesterol test result should be recorded with the following units: **mg/dl**.
- Enter the date (MM/DD/YYYY) each **cholesterol** test was taken.

LDL
- Enter each **LDL (Low Density Lipoprotein)** laboratory result for the <u>**past 12 months**</u>.
- The **LDL** lab result should be recorded with the following units: **mg/dl**.
- Enter the date (MM/DD/YYYY) each **LDL** test was taken.

HDL

- Enter each **HDL (High Density Lipoprotein)** laboratory result for the <u>**past 12 months**</u>.
- The **HDL** laboratory result should be recorded with the following units: **mg/dl**.
- Enter the date (MM/DD/YYYY) each **HDL** test was taken.

TG (triglycerides)
- Enter each **TG (triglycerides)** laboratory result for the <u>**past 12 months**</u>.
- The **TG** laboratory result should be recorded with the following units: **mg/dl**.
- Enter the date (MM/DD/YYYY) each **TG** test was taken.

HbA1c
- For persons diagnosed with diabetes, enter each **HbA1c (Hemoglobin A1c)** test result for the <u>**past 12 months.**</u>
- The **HbA1c** laboratory test result should be recorded with the following units: **%**.
- Enter the date (MM/DD/YYYY) each **HbA1c** test was taken.

Glucose
- Enter each **Glucose** test result for the <u>**past 12 months**</u>.
- If patient was fasting circle **Y** (yes) or circle **N** (no) if patient was not fasting. If information is unknown about whether the patient was fasting, circle **UNK** (unknown).
- The **Glucose** laboratory test result should be recorded with the following units: **mg/dl**.
- Enter the date (MM/DD/YYYY) each **glucose** test was taken.

Hemoglobin
- Enter each **hemoglobin** test result for the **past 12 months.**
- The **hemoglobin** laboratory result should be recorded with the following units: g/dL
- Enter the date (MM/DD/YYYY) each **hemoglobin** test was taken.

LFTs (Liver function tests)
- Enter each **ALT** (alanine transaminase) and **AST** (aspartate transaminase) test result for the **past 12 months.**
- The **ALT** and **AST** laboratory results should be recorded with the following units: **units/L.**
- Enter the date (MM/DD/YYYY) each **LFT** test was taken.

Bilirubin
- Enter each total **Bilirubin** test results for the **past 12 months.**
- The **Bilirubin** test result should be recorded with the following units: **mg/dL.**
- Enter the date (MM/DD/YYYY) each **Bilirubin** test was taken.

Creatinine
- Enter each *serum* **Creatinine** test results for the **past 12 months.**
- The serum **Creatinine** laboratory result should be recorded with the following units: **mg/dl.**
- Enter the date (MM/DD/YYYY) each serum **Creatinine** test was taken.

Urinalysis
- For each **urinalysis** performed over the *past 12 months*, circle **"+ protein"** if protein was found in urine or **"– protein"** if no protein was found in the urine.
  - If trace protein was found in urine, circle **"+ protein"**
- Enter the date (MM/DD/YYYY) each **urinalysis** test was taken.

Basic Chemistry Panel
- If a **basic chemistry panel** was completed over the *past 12 months*, circle **Y** (yes) or circle **N** (no) if no **basic chemistry panel** was completed over the *past 12 months*.
  - A **basic chemistry panel** refers to 7 common laboratory tests including sodium, potassium, chloride bicarbonate, blood urea nitrogen, creatinine and glucose.
  - If results for the above mentioned tests are available over the past 12 months, circle **Y** (yes)
- Enter the date (MM/DD/YYYY) each **basic chemistry panel** test was completed.

HBV DNA
- If the patient is co-infected with **HBV (hepatitis B virus)**, enter each HBV DNA test result for the *past 12 months*.
- The **HBV DNA** test result should be recorded with the following units: **copies/mL.**
- Enter the date (MM/DD/YYYY) the **HBV DNA** test was taken.

HCV RNA

- If the patient is co-infected with **HCV (hepatitis C virus)**, enter each HCV RNA test result for the ***past 12 months***.
- The **HCV RNA** test result should be recorded with the following units: **copies/mL.**
- Enter the date (MM/DD/YYYY) the **HCV RNA** test was taken.

Syphilis
- If Syphilis screening (s) were completed in the ***past 12 months***, select if the result was **negative** or **positive**.
- Enter the date (MM/DD/YYYY) each **Syphilis** test was taken.

E. Please provide the following information on viral hepatitis testing:

Has the patient ever been tested for HBsAg (hepatitis B surface antigen)?
- Select the applicable response: "yes" or "no"
- If it is unknown if patient was tested for **HBsAg**, check **"Unknown".**
- If patient has been tested for HBsAg, select if the result was **negative** or **positive**.

Has the patient ever been tested for anti-HBs (antibody to hepatitis B surface antigen)?
- Select the applicable response: "yes" or "no"
- If it is unknown if patient was tested for **anti-HBs**, check **"Unknown".**
- If patient has been tested for anti-HBs, select if result was >**10 mlU/mL (positive)** or **<10 mlU/mL (negative).**

Has the patient ever been tested for anti-HCV (antibody to hepatitis C virus)?
- Select the applicable response: "yes" or "no"
- If it is unknown if patient was rested for anti-HCV, check **"Unknown".**
- If patient has been tested for anti-HCV, select if the result was **negative** or **positive**.

If anti-HCV test was positive, was a confirmatory test done?
- Select the applicable response: "yes" or "no"
    - Hepatitis C confirmatory tests include recombinant immunoblot assay (RIBA) and hepatitis C RNA tests
- If it is unknown if a confirmatory test was done, check **"Unknown".**
- If patient had a confirmatory test for hepatitis C, select if the result was **negative** or **positive**.

IV. Immunizations

Enter whether patient has received the listed immunizations, the number of doses for each vaccine, dates vaccinated and whether the patient completed the vaccination series (if applicable). Include all vaccines received at any time in the patient's history—DO NOT limit to vaccines received only at this clinic.

VACCINATION RECEIVED EVER:

- Select "**yes**," if patient has *ever* **received the vaccination, select "no" if patient has never received the vaccination**.
- If **no**, leave columns "number of doses" "dates" and "series **blank**.
- If vaccination status is unknown, check **"Unknown".**

NUMBER OF DOSES:
- If patient received vaccine, enter the **number of doses** received.

DATES:
- Enter **date** (MM/DD/YYYY) for each dose of vaccine received
- For recurrent vaccines (i.e. Influenza and Tetanus) list the date for the most recent dose.
- If the exact date is not known, provide as much information as possible. For example, if the day that patient was vaccinated is unknown but the month and year are known, provide the month (MM) and year (YYYY).

SERIES COMPLETED?:
- For vaccines that are given as a **series of doses** (see list below), indicate if the vaccination **series was completed**.

Vaccine	Doses in vaccine series
Hepatitis A vaccine	2 doses
Hepatitis B vaccine	3 doses
Hepatitis A/B vaccine	3 doses
Human papilloma virus vaccine	3 doses

- If no series completion information is available, check **"Unknown".**

V. Medications

FOR ALL DATES, if the exact date is not known, provide as much information as possible. For example, if the day is unknown but the month and year are known, provide the month (MM) and year (YYYY).

A. Has patient ever taken ART (antiretroviral therapy)?
- Select the applicable response: "yes" or "no"
  - o If patient has ever taken ≥1 antiretroviral medication, select "yes"

If yes, what was the date of first ever ART:

- Enter date (MM/DD/YYYY) patient was first started on ART. The date should be the first date of ART use which may not be the same date as the date the patient started on ART at the current clinic.
- If date of first ART use is not known, select "**Unknown**"
- If patient has never been on ART, select **"N/A"** (not applicable)

Is patient currently taking ART?
- Select the applicable response: "yes" or "no"

If no, date of last use:
- Enter date (MM/DD/YYYY) when patient last used ART
- If patient has never used ART, select **"N/A"** (not applicable)
- If date when patient last used ART is not known, select "**Unknown**"

Has an HLA-B*5701 test been done?
- Select the applicable response: "yes" or "no"

If yes, what was the result of the HLA-B*5701 test?
- Select the applicable response: "negative" or "positive"

Has a tropism assay been done?
- Select the applicable response: "yes" or "no"

If yes, what were the results?
- Select the applicable response: "CCR5 positive" or "CXCR4 positive" or "dual or mixed tropism"

B. Current ART Medications (Table)

If patient is not currently on any ART, <u>SKIP</u> this table

NAME OF <u>CURRENT </u>ART MEDICATIONS:
- List the **name(s)** of <u>ALL</u> ART medications the patient is <u>**currently**</u> taking.
- *Fixed dose combination medications, such as Atripla, should be listed on one line.*

DOSAGE (mg):
- List the **dosage (mg)** of each current ART medication.
- *Fixed dose combination medications, such as Atripla, should be listed on one line.*
- For fixed dose combination medications, such as Atripla, the dosage (mg) of each component should be separated by a "/". For example, Atripla 600/200/300 .
- *If a patient is prescribed a medication with two separate doses, please list each dose on a separate line*

FREQUENCY:
- List the prescribed **frequency** for the ART medication (e.g. once daily, three times per day)
- Do not use abbreviations (e.g. qd for once daily). Instead, fully write out the prescribed frequency (e.g. twice daily)

START DATE:

- List the date (MM/DD/YYYY) the patient's provider started the patient on each medication

Example:

Name of Current ART Medications*	Dosage (mg)	Frequency	Prescription start date
Atripla	600/200/300	Once daily	01/15/2013

C. Please provide a list of ALL former ART medications ever taken

NAME OF ALL FORMER ART MEDICATIONS EVER TAKEN:
- List the name(s) of **ALL former ART medications *ever*** taken by the patient.
- ***Fixed dose combination medications, such as Atripla, should be listed on one line.***

DOSAGE (mg):
- List the **dosage (mg)** of each former ART medication.
- For fixed dose combination medications, such as Atripla, the dosage (mg) of each component should be separated by a "/". For example, Atripla 600/200/300 .
- ***If a patient is prescribed a medication with two separate doses, please list each dose on a separate line***

FREQUENCY:
- List the prescribed **frequency** for each former ART medication (e.g. once daily, three times per day).
- Do not use abbreviations (e.g. qd for once daily). Instead, fully write out the prescribed frequency (e.g. twice daily)

START DATE:
- List the date (MM/DD/YYYY) the patient's provider started the patient on each medication

DATE DISCONTINUED:
- List the **date** (MM/DD/YYYY) the patient **discontinued** the ART medication.

REASON FOR DISCONTINUATION:
- Select the applicable response for why medication was discontinued: "tolerability" "toxicity/side effects" "failure" or "other"
- If "other" is selected, provide a brief reason as to why the medication was discontinued

Example:

Name of ALL Former ART Medications ever taken	Dosage (mg)	Frequency	Start date	Date discontinued	Reason for discontinuation
Lamivudine	150	Twice daily	01/05/2009	06/23/2009	☐ tolerability

					X toxicity / side effects □ failure □ other _____

D. List all medications that the patient is CURRENTLY taking for opportunistic infection (OI) treatment or prevention.

NAME OF CURRENT MEDICATIONS FOR OIs:
- List the **name** of all **medication(s)** patient is **currently** taking for *treatment* or *prophylaxis* of Opportunistic Infections (OI).

NAME OF OI:
- List the **name** of the **Opportunistic Infection (OI)** for which treatment or prophylaxis is being provided.

TREATMENT/PROPHYLAXIS:
- Select box for **"treatment"** if patient is on the listed OI medication for treatment or select **"prophylaxis"** if the patient is on the OI medication for prophylaxis

DOSAGE (mg):
- List the **dosage (mg)** of the prescribed OI medication.
- For fixed dose combination medications the dosage (mg) of each component should be separated by a "/". For example, Bactrim 800/160 .
- *If a patient is prescribed a medication with two separate doses, please list each dose on a separate line*

FREQUENCY:
- List the prescribed **frequency** for the OI medication (e.g. once daily, three times per day).
- Do not use abbreviations (e.g. qd for once daily). Instead, fully write out the prescribed frequency (e.g. twice daily)

START DATE:
- List the **date** (MM/DD/YYYY) the patient **started** the OI medication.

Example:

Name of Current Medication for OIs	Name of OI	Dosage (mg)	Frequency	Start date
Bactrim DS	Pneumocystis carinii pneumonia □ **treatment**	800/160	Once daily	11/16/2013

	X prophylaxis			
Fluconazole	Oral thrush	100	Once daily	03/01/2013
	X treatment ☐ prophylaxis			

E. List all medications that the patient has FORMERLY taken for opportunistic infection (OIs) treatment or prevention over the past 24 months.

NAME OF FORMER MEDICATIONS FOR OIs
- List the **name(s)** of all **former medication**(s) patient has taken for *treatment* or prophylaxis of Opportunistic Infections (OIs) in the past 24 months.

NAME OF OI
- List the **name(s)** of the **OIs** for which treatment or prophylaxis was provided

TREATMENT/PROPHYLAXIS:
- Select box for **"treatment"** if patient was on the listed OI medication for treatment or select "**prophylaxis**" if the patient was on the OI medication for prophylaxis.

DOSAGE:
- List the **dosage (mg)** of the listed OI medication.
- For fixed dose combination medications the dosage (mg) of each component should be separated by a "/". For example, Bactrim 800/160 .
- ***If a patient is prescribed a medication with two separate doses, please list each dose on a separate line***

FREQUENCY:
- List the prescribed **frequency** for the OI medication (e.g. once daily, three times per day).
- Do not use abbreviations (e.g. qd for once daily). Instead, fully write out the prescribed frequency (e.g. twice daily)

START DATE:
- List the **date** (MM/DD/YYYY) the patient **started** the OI medication.

DATE DISCONTINUED:
- List the **date** (MM/DD/YYYY) the patient **discontinued** the **OI** medication.

Example:

Name of Former Medication for OIs	Name of OI	Dosage (mg)	Frequency	Start date	Date Discontinued
Fluconazole	Oral thrush	100	Once daily	03/01/2008	03/15/2008

	X treatment ☐ prophylaxis				

F. List other CURRENT medications

NAMES OF OTHER UNDERLINE CURRENT MEDICATIONS:
- List the **name(s) of ALL other current medications** the patient is taking.
    - This includes all medications for other chronic and/or acute conditions.
    - This also includes non-prescription medications such as over-the-counter-medications, herbal products and supplements

DOSAGE (mg)
- Provide the **dosage (mg)** of each listed medication.
- For fixed dose combination medications the dosage (mg) of each component should be separated by a "/". For example, Bactrim 800/160 .
- *If a patient is prescribed a medication with two separate doses, please list each dose on a separate line*

FREQUENCY
- Provide the prescribed **frequency** for each listed medication.
- Do not use abbreviations (e.g. qd for once daily). Instead, fully write out the prescribed frequency (e.g. twice daily)

START DATE
- Provide the **start** date (MM/DD/YYYY) for each listed medication.

Example:

Names of Other Current Medications	Dosage (mg)	Frequency	Start date
Metformin	1000	Twice daily	05/21/2000
Metformin	500	Once daily	05/21/2000

VI. Current Medical History and Allergies

G. Please list all current medical problems including mental illnesses
- List all of the patient's current medical problems including mental illnesses.
- List each condition and mental diagnosis separately.

H. Please list all known drug allergies
If patient has no known drug allergies please check the following box:
- If patient has no known drug allergies, select "**no known drug allergies**"

NAME OF MEDICATION

- List the name of each medication to which the patient is allergic.

REACTION TO MEDICATION
- Provide a brief description of the reaction the patient has to each medication.

Example

Name of medication	Reaction to medication
Penicillin	rash

VII. Tobacco, Drug, and Alcohol Use

Is the patient a smoker?
- Select the applicable response: "yes" or "no" or "no, but past use"
- If patient's smoking status is unknown, check "**Unknown**"

If patient is former smoker, how long ago did patient quit?
- Enter the **years**/**months** since the patient quit smoking.
- If time since quitting smoking is unknown, check "**Unknown**"

If patient is a <u>present</u> or <u>past</u> smoker, what is the pack year smoked?
- If the patient is a present or former smoker enter the number of **pack years smoked**.
  - Pack years smoked = (packs smoked per day) x (years as a smoker)
  - For example, if patient has been smoking 2 packs per day for 12 years, the pack years smoked is 24 (2 x 12)
- If patient has never smoked, check **"N/A"** (not applicable)

Does the patient use illegal drugs or abuse prescription controlled substances?
- **Injection drug use**
  - Select the applicable response: "yes" or "no" or "no, but past use"

  - If injection drug use status is unknown, check "**Unknown**"
- **Non-injection drug use**
  - Select the applicable response: "yes" or "no" or "no, but past use"
  - If non-injection drug use status is unknown, check "**Unknown**"

Is patient currently or has patient ever been in a substance abuse program?
- If the patient has never had a substance abuse problem, check **"N/A"**
- Select the applicable response: "yes, currently in a program" or "yes, in the past" or "no"
- If whether the patient has ever attended a substance abuse program is unknown, check "**Unknown**"

If patient has ever been in a substance abuse treatment program, did patient complete the program?
- If patient has never been in a substance abuse treatment program, check **"N/A"**
- Select the applicable response: "yes" or "no"

- If whether the patient has completed a substance abuse treatment program is unknown, check **"Unknown"**

Does the patient drink alcohol heavily?
- Select the applicable response: "yes" or "no" or "no, but past use"
  - Heavy alcohol consumption for males is defined as ≥5 drinks on any single day or ≥15 drinks per week; for women heavy alcohol consumption is defined as ≥4 drinks on any single day or ≥8 drinks per week
- If alcohol consumption is unknown, check "**Unknown**"

If patient is a former heavy drinker, how long has patient been abstinent?
- If patient has never been a heavy drinker, check **"N/A"**
- Enter the time (**years/months**) for which patient has been abstinent
- If it is not known how long the patient has been abstinence, check "**Unknown**"

Is patient currently or has patient ever been in an alcohol abuse program?
- Select the applicable response.
- If patient has never been a heavy drinker, check **"N/A"**
- If whether a patient has ever attended an alcohol abuse program is unknown, check "**Unknown**"

If patient has ever been in an alcohol abuse treatment program, did patient complete the program?
- Select the applicable response: "yes" or "no"
- If patient has never been in a alcohol abuse treatment program, check **"N/A"**
- If whether the patient has completed a substance abuse treatment program is unknown, check **"Unknown"**

VIII. Clinic Appointment Information

Is patient new to this clinic or new to HIV care?
- Select the applicable response: "yes" or "no"

Please list ALL appointments (medical, case management, mental health, substance abuse) scheduled for the patient in the past 24 months and note if appointment was kept

Each box should include 3 pieces of information: 1) type of _scheduled_ appointment (medical visit, case management, mental health, substance abuse) 2) the date of the appointment and 3) whether the appointment was kept by the patient

- Use one box for **each** appointment.
- Select the applicable response for type of appointment
  - A **medical visit** should be selected if a patient was seen by a physician, nurse practitioner or physician's assistant

      o   Appointments for **case management** may include appointments with a social worker
- Enter the date (MM/DD/YYYY) of the appointment
- Select **"yes"** if the patient kept the appointment or **"no"** if the patient did not keep the appointment. If it is unknown if the patient kept the appointment, check **"Unknown"**
- If there are more than 12 clinic appointments to be reported use the additional table at the end of the *Initial Patient Information form* (page xx).

Example:

Type of appointment	Date	Was appt. kept?	Type of appointment	Date	Was appt. kept?
Medical visit* **X**	_09_ / _13_ /2013	**X** yes ☐ no	Medical visit* ☐	_11/29_ /2013	☐ yes **X** no
Case management†		☐ Unknown	Case management ☐		☐ Unknown
Mental Health ☐			Mental Health **X**		
Substance Abuse ☐			Substance Abuse ☐		

IX. Follow-up

When is patient's next scheduled medical visit with a physician, nurse practitioner, or physician's assistant?

- Enter the date (MM/DD/YYYY) of patient's next scheduled medical visit with a physician, nurse practitioner or physician's assistant
- Select "no appointment scheduled" if no appointment has been scheduled

When is the patient's first scheduled MTM appointment?

- Enter the (MM/DD/YYYY) of the first scheduled Walgreens MTM (Medication Therapy Management) appointment
- Select "no appointment scheduled" if no appointment has been scheduled

NOTES: (Provide additional information if needed)