Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Form Approved
OMB No: 0920-XXXX
Exp. Date: XX/XX/XXXX

Quarterly Patient Information Form

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

FOR PARTNERED SITES USE ONLY

Have there been any changes to the patient's or clinic's contact information? ☐ yes ☐ no

If yes, please complete the following table:

FOR PROGRAM USE ONLY		
Patient information		
Address:		
City:	State:	Zip code:
Phone number: (____) _____-_____	☐ home	☐ mobile
Phone number: (____) _____-_____	☐ home	☐ mobile
Email address:		
Clinic information		
Provider name:		
Clinic name:	Clinic phone number: (____) _____-_____	
	Clinic fax number: (____) _____-_____	
Primary clinic contact person:	Contact phone number: (____) _____-_____	
	Email address:	
Secondary clinic contact person:	Contact phone number: (____) _____-_____	
	Email address:	

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Quarterly Patient Information Form

Date: ___/___/____

Patient Project ID: _____

Has patient had a medical visit with a physician, nurse practitioner or physician's assistant since the last quarterly review? ◻ yes ◻ no

If patient did not have medical visit with a physician, nurse practitioner or physician's assistant since the last quarterly review, has the patient been seen in the clinic *for any reason* (e.g. case management, mental health) or had labs drawn in the past 6 months?
◻ yes ◻ no

If no, state the reason why the patient is not continuing care *or* has not been seen in the clinic in the past 6 months

- ◻ Patient has missed scheduled appointments date: ____/_____/_____ ◻ Unknown
- ◻ Patient died date: ____/_____/_____ ◻ Unknown
- ◻ Patient too ill (e.g. hospitalized, nursing home, hospice care) date: ____/_____/_____ ◻ Unknown
- ◻ Moved out of area date: ____/_____/_____ ◻ Unknown
- ◻ Transferred care to another provider date: ____/_____/_____ ◻ Unknown
- ◻ Incarcerated date: ____/_____/_____ ◻ Unknown
- ◻ Voluntary withdraw from project date: ____/_____/_____ ◻ Unknown
- ◻ Don't know/ unsure what happened to patient date: ____/_____/_____ ◻ Unknown
- ◻ Other: _____ date: ____/_____/_____ ◻ Unknown

If patient has not been seen in the clinic for any reason AND has not had labs drawn in the past 6 months, STOP

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Patient Information

Has there been a change in insurance status?: □ no □ yes, patient has a new insurer □ yes, patient is no longer insured □ Unknown

If patient has a new insurer please provide the name of new insurer: _____

Most recent Weight: _____ (lbs/kg (circle)) Date: ___/___/____

All dates should be in the MM/DD/YYYY format

Was patient's blood pressure taken since the last quarterly update? □ no □ yes

If yes, please provide patient's blood pressure values since the last quarterly update

Blood pressure: ___/____ Date: ___/___/____

Blood pressure: ___/____ Date: ___/___/____

Blood pressure: ___/____ Date: ___/___/____

I. Patient Lab Information:

A. Please update lab information since the last quarterly review

Laboratory Tests	Value/Date	Value/Date	Value / Date	Value/Date
CD4 (cells/ µL and %) **Was lab drawn?** □ no □ yes	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending
HIV-1 RNA/DNA NAAT (Quantitative viral load) (copies/mL) **Was lab drawn?** □ no □ yes	Copies/mL: _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

B. Please update laboratory information since the last quarterly review

Laboratory Test/Screenings	**Value/Date**	**Value/Date**	**Value / Date**	**Value/Date**
Total Cholesterol (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
LDL: (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HDL: (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
TG: (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HbA1c (only if diagnosed with diabetes): **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Glucose: (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Hemoglobin: **Was lab drawn?**	_____	_____	_____	_____

□ no □ yes	□ pending	□ pending	□ pending	□ pending
LFTs (units/L) **Was lab drawn?** □ no □ yes	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending
Bilirubin (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Creatinine **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Urinalysis **Was lab done?** □ no □ yes	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending
Was a basic chemistry panel completed?	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending
HBV DNA (if HBV co-infected) (copies/mL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HCV RNA (if HCV co-infected) (copies/mL)	_____ ___/___/____	_____ ___/___/____	_____ ___/___/____	_____ ___/___/____

Was lab drawn? □ no □ yes	□ pending	□ pending	□ pending	□ pending
Syphilis screening **Was lab drawn?** □ no □ yes	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending

N/A = not applicable

C. Please provide the following information on viral hepatitis testing since the last quarterly review

Viral Hepatitis			
Has the patient been tested for HBsAg* since the last quarterly update?	□ yes	□ no	□ Unknown
	If yes, results:	□ negative	□ positive
Has the patient been tested for anti-HBs^ since the last quarterly update?	□ yes	□ no	□ Unknown
	If yes, results:	□ >10 mIU/mL	□ < 10 mIU/mL
Has the patient been tested for anti-HCV‡ since the last quarterly update?	□ yes	□ no	□ Unknown
	If yes, results:	□ negative	□ positive
If anti-HCV test was positive, was a confirmatory test done?	□ yes	□ no	□ Unknown
	If yes, results:	□ negative	□ positive

*HBsAg = hepatitis B surface antigen
^Anti-HBs = antibody to the hepatitis B surface antigen
‡Anti-HCV = antibody to hepatitis C virus

II. Medication Updates

A1. Please list all antiretroviral therapy (ART) medications that the patient <u>CURRENTLY</u> takes (at the time of quarterly update)

Name of <u>current</u> *ART* medications	Dosage	Frequency	Start date
			___/___/____

			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____

Have there been any changes to the patient's ART since last quarterly update? □ no □ yes

Has an HLA-B*5701 test been done? □ yes □ no

If yes, what was the result of the HLA-B*5701 test? □ negative □ positive

Has a tropism assay been done? □ yes □ no

If yes, what were the results?

□ CCR5 positive □ CXCR4 positive □ dual or mixed tropism

A2. List all <u>NEW</u> ART medications initiated since last quarterly update

Name of <u>new</u> *ART* medication	Dosage	Frequency	Start date
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____

A3. List all <u>DISCONTINUED</u> ART medications since last quarterly update

Name of <u>discontinued</u> *ART* medication	Date discontinued	Reason for discontinuation
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____
	___/___/____	□ tolerability □ toxicity / side effects □ failure □ other _____

B1. Please list all other medications that the patient <u>CURRENTLY</u> takes (at the time of quarterly update)

Name of other <u>current</u> medication	Dosage	Frequency	Start date
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____
			___/___/____

Have there been any changes to the patient's other medications (non-HIV medications) since last quarterly update? □ no □ yes

B2. List all NEW non-HIV medications initiated since last quarterly update

Name of new non-*HIV* medication	Dosage	Frequency	Reason for Initiation	Start date
				___/___/____
				___/___/____
				___/___/____
				___/___/____
				___/___/____
				___/___/____

B3. List all DISCONTINUED non-HIV medications since last quarterly update

Name of discontinued non-*HIV* medication	Date discontinued	Reason for discontinuation
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________
	___/___/____	◻ tolerability ◻ toxicity / side effects ◻ failure ◻ no longer indicated ◻ other ____________

III. Medical History and Allergies Updates

A. Were there any newly diagnosed medical conditions or problems at any time since the last quarterly update?

□ yes □ no

If yes, list all newly diagnosed medical conditions and problems

Newly diagnosed medical conditions or new medical problems	Date diagnosed
	___/___/____
	___/___/____
	___/___/____
	___/___/____
	___/___/____
	___/___/____

B. Were there any resolved medical problems at any time since the last quarterly visit?

□ yes □ no

If yes, list all resolved medical problems

Resolved medical problems	Date resolved
	___/___/____
	___/___/____
	___/___/____

	___/___/____
	___/___/____
	___/___/____

C. Were they any newly diagnosed drug allergies since the last quarterly update? ◻ yes ◻ no

If yes, list all new drug allergies

Name of medication	Reaction to medication	Date allergy developed
		___/___/____
		___/___/____
		___/___/____
		___/___/____
		___/___/____
		___/___/____

IV. Tobacco, Drug and Alcohol use

Has patient's smoking status changed since last quarterly update?			◻ yes ◻ no	◻ Unknown
If yes, how has smoking status changed?				
◻ N/A	◻ increased amount smoked	◻ decreased amount smoked		
◻ new smoker Date started: ___/___/____		◻ quit smoking Date quit: ___/___/____		
Has patient's illegal drug use/abuse of prescription controlled substances changed since last quarterly update?			◻ yes ◻ no	◻ Unknown
If yes, how has drug abuse status changed?				
◻ N/A	◻ increased amount used	◻ decreased amount used		
◻ new user Date started: ___/___/____		◻ quit using Date quit: ___/___/____		
Has patient initiated or completed substance abuse treatment since last quarterly update?				
◻ N/A	◻ yes, currently in a	◻ yes, completed a	◻ no	◻ Unknown

	program	program		
Has patient's heavy alcohol consumption changed since last quarterly update? Heavy alcohol consumption for males equals ≥5 drinks on any single day or ≥15 drinks per week; for women heavy alcohol consumption equals ≥4 drinks on any single day or ≥8 drinks per week			□ yes	□ no □ Unknown
If yes, how has alcohol consumption changed?				
□ N/A	□ increased drinking		□ decreased drinking	
□ new heavy drinker Date started: ___/___/____			□ quit drinking Date quit: ___/___/____	
Has patient initiated or completed alcohol abuse treatment since last quarterly update?				
□ N/A	□ yes, currently in a program	□ yes, completed a program	□ no	

V. Immunization History

Did client receive any immunizations *at this clinic* since last quarterly update? **□ yes □ no**

If yes, which immunization(s) was provided? _____ **date** ____/_____/_____

_____ **date** ____/_____/_____

_____ **date** ____/_____/_____

VI. Clinic Appointment Information

Was patient scheduled for *any* appointments (e.g. medical, case management, mental health, substance abuse) since last quarterly update? □ yes □ no □ Unknown

If yes, please list ALL appointments (medical, case management, mental health, substance abuse) scheduled for the patient since the last quarterly update and note if appointment was kept

Include only one appointment type and date in each box

Type of appointment	Date	Was appt. kept?	Type of appointment	Date	Was appt. kept?
Medical visit* □ Case management† □ Mental Health □ Substance Abuse □	____/_____/_____	□ yes □ no □ Unknown	Medical visit* □ Case management† □ Mental Health □ Substance Abuse □	____/_____/_____	□ yes □ no □ Unknown
Medical visit* □ Case management† □ Mental Health □	____/_____/_____	□ yes □ no □ Unknown	Medical visit* □ Case management† □ Mental Health □	____/_____/_____	□ yes □ no □ Unknown

Substance Abuse ◻	Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻
Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻	Medical visit* ◻ ____/_____/_____ ◻ yes ◻ no Case management† ◻ ◻ Unknown Mental Health ◻ Substance Abuse ◻

*a medical appointment with a physician, nurse practitioner or physician's assistant
†appointment with Case management or a Social Worker

VII. Medication Therapy Management (MTM)

Was documentation of patient's MTM visit(s) received by the clinic? ◻ yes ◻ no

If yes, complete the following table for each MTM communication received since last quarterly update:

Date MTM information received at clinic	How MTM information was sent to clinic	Did provider acknowledge receipt of MTM information?
____/_____/_____	◻ fax ◻ in person ◻ other ___________	◻ yes date: ____/_____/_____ ◻ no ◻ unknown

____/_____/_____	□ fax □ in person □ other _____	□ yes date: ____/_____/_____ □ no □ unknown
____/_____/_____	□ fax □ in person □ other _____	□ yes date: ____/_____/_____ □ no □ unknown
____/_____/_____	□ fax □ in person □ other _____	□ yes date: ____/_____/_____ □ no □ unknown
____/_____/_____	□ fax □ in person □ other _____	□ yes date: ____/_____/_____ □ no □ unknown

VII. Follow-up

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

date: ____/_____/_____ □ no appointment scheduled

When is patient's next scheduled Medication Therapy Management (MTM) appointment?

date: ____/_____/_____ □ no appointment scheduled

NOTES:

_____

_____

_____

_____

_____

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

ADDITIONAL LABORATORY TEST VALUES
(use if needed to record additional laboratory test values)

Please provide the following laboratory values for the *past 24 months*

Laboratory Tests	Value/Date	Value/Date	Value / Date	Value/Date
CD4 (cells/ µL and %) **Was lab drawn?** □ no □ yes	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending	_____ cells/µL _____ % ___/___/____ □ pending
HIV-1 RNA/DNA NAAT (Quantitative viral load) (copies/mL) **Was lab drawn?** □ no □ yes	Copies/mL: _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending	Copies/mL _____ ___/___/____ □ pending

Please provide the following laboratory values for the *past 12 months*:

Laboratory Test/Screenings	Value/Date	Value/Date	Value / Date	Value/Date
Total Cholesterol (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
LDL: (mg/dL) **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HDL: (mg/dL)	_____	_____	_____	_____

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Was lab drawn? □ no □ yes	___/___/____ □ pending	___/___/____ □ pending	___/___/____ □ pending	___/___/____ □ pending
TG: **(mg/dL)** **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HbA1c (only if diagnosed with diabetes): **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Glucose: **(mg/dL)** **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Hemoglobin: **Was lab drawn?** □ no □ yes	_____ □ pending	_____ □ pending	_____ □ pending	_____ □ pending
LFTs **(units/L)** **Was lab drawn?** □ no □ yes	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending	ALT _____ AST _____ ___/___/____ □ pending
Bilirubin **(mg/dL)** **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Creatinine	_____	_____	_____	_____

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Was lab drawn? □ no □ yes	___/___/____ □ pending	___/___/____ □ pending	___/___/____ □ pending	___/___/____ □ pending
Urinalysis **Was lab done?** □ no □ yes	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending	+ protein - protein ___/___/____ □ pending
Was a basic chemistry panel completed?	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending	Y / N ___/___/____ □ pending
HBV DNA **(if HBV co-infected)** **(copies/mL)** **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
HCV RNA **(if HCV co-infected)** **(copies/mL)** **Was lab drawn?** □ no □ yes	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending	_____ ___/___/____ □ pending
Syphilis screening **Was lab drawn?** □ no □ yes	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending	□ negative □ positive ___/___/____ □ pending

Patient Project ID: ___________
Staff Project ID: ___________
Clinic Project ID: ___________

ADDITIONAL CLINIC APPOINTMENT INFORMATION
(use if needed to record clinic appointment information)

Type of appointment	Date	Was appt. kept?	Type of appointment	Date	Was appt. kept?
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown

*a medical appointment with a physician, nurse practitioner or physician's assistant
†appointment with Case management or a Social Worker

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____