

Form Approved
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Initial Patient Information Form

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FOR PARTNERED SITES USE ONLY

FOR PROGRAM USE ONLY		
Patient information		
Address:		
City:	State:	Zip code:
Phone number: (____) _____ - _____	<input type="checkbox"/> home	<input type="checkbox"/> mobile
Phone number: (____) _____ - _____	<input type="checkbox"/> home	<input type="checkbox"/> 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:	

Date: ___/___/___

Initial Patient Information Form

I. Patient Demographic Information					
Date of Birth (month/year)		____/____			
Sex: (check all that apply)					
<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Transgender	
Race (check all that apply)					
<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Other: _____
Ethnicity					
<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Not Hispanic/Latino		<input type="checkbox"/> Unknown	
Education level					
<input type="checkbox"/> less than high school	<input type="checkbox"/> high school only	<input type="checkbox"/> some college	<input type="checkbox"/> college or above	<input type="checkbox"/> Unknown	
Number of people in household: _____ <input type="checkbox"/> Unknown					
Annual household income					
<input type="checkbox"/> < \$15,000	<input type="checkbox"/> ≥ \$15,000 - < \$30,000		<input type="checkbox"/> ≥ \$30,000	<input type="checkbox"/> Unknown	
Housing status					
<input type="checkbox"/> currently homeless	<input type="checkbox"/> not currently, but homeless in the past 12 months	<input type="checkbox"/> homeless previously, but not homeless in the past 12 months		<input type="checkbox"/> Never homeless	<input type="checkbox"/> Unknown
Employment status (check all that apply)					
<input type="checkbox"/> unemployed	<input type="checkbox"/> employed	<input type="checkbox"/> disabled	<input type="checkbox"/> student	<input type="checkbox"/> retired	<input type="checkbox"/> Unknown
If patient is employed, is he/she employed part time or full time?					
<input type="checkbox"/> N/A		<input type="checkbox"/> part time		<input type="checkbox"/> full time <input type="checkbox"/> Unknown	
Medical Insurance status (check all that apply)					
<input type="checkbox"/> Private insurance	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Ryan White/ADAP	<input type="checkbox"/> uninsured	<input type="checkbox"/> Unknown

Date of patient's first visit to THIS clinic: ____/____/____ (MM/DD/YYYY)

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

II. Diagnosis Information

Date of HIV Diagnosis: ____/____/____ (MM/DD/YYYY) Unknown

Disease Stage at diagnosis: stage 1 HIV stage 2 HIV stage 3 AIDS stage Unknown Unknown

Date first entered into care for HIV: ____/____/____ Unknown

*enter the date the patient first entered into HIV care which might not be the date the patient first entered into care at this clinic

III. Patient Laboratory Information and Vital signs

A. Please provide the following information:

Height: _____ (inches) Date: ____/____/____

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

B. Please provide patient's blood pressure values for the past 12 months

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

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

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

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

C. Please provide the following laboratory values for the past 24 months

Please use the additional tables at the end of the form if there are more than four lab values over the past 12 months

Laboratory Test	Value/Date	Value/Date	Value/Date	Value/Date
CD4 (cells/ μ L and %)	____ cells/ μ L	____ cells/ μ L	____ cells/ μ L	____ cells/ μ L
	____ %	____ %	____ %	____ %
	____/____/____	____/____/____	____/____/____	____/____/____
HIV-1 RNA/DNA NAAT (Quantitative viral load)	Copies/mL: _____	Copies/mL _____	Copies/mL _____	Copies/mL _____

(copies/mL)	____/____/____	____/____/____	____/____/____	____/____/____
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D. Please provide the following laboratory values for the past 12 months:

Please use the additional tables at the end of the form if there are more than four lab values over the past 12 months

Laboratory Test/Screenings	Value/Date	Value/Date	Value / Date	Value/Date
Total Cholesterol (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
LDL: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
HDL: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
TG: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
HbA1c (only if diagnosed with diabetes):	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
Glucose: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
Hemoglobin:	_____	_____	_____	_____
LFTs (units/L)	ALT _____	ALT _____	ALT _____	ALT _____

	AST _____ ____/____/____	AST _____ ____/____/____	AST _____ ____/____/____	AST _____ ____/____/____
Bilirubin (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
Creatinine	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
Urinalysis	+ protein - protein ____/____/____	+ protein - protein ____/____/____	+ protein - protein ____/____/____	+ protein - protein ____/____/____
Was a basic chemistry panel completed?	Y / N ____/____/____	Y / N ____/____/____	Y / N ____/____/____	Y / N ____/____/____
HBV DNA (if HBV co-infected) (copies/mL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
HCV RNA (if HCV co-infected) (copies/mL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
Syphilis screening	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____

Y = yes
N = no
UNK = Unknown

E. Please provide the following information on viral hepatitis testing

Viral Hepatitis			
Has the patient ever been tested for HBsAg*?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
	If yes, results:	<input type="checkbox"/> negative	<input type="checkbox"/> positive
Has the patient ever been tested for anti-HBs^?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
	If yes, results:	<input type="checkbox"/> >10 mIU/mL	<input type="checkbox"/> < 10 mIU/mL
Has the patient ever been tested for anti-HCV‡?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
	If yes, results:	<input type="checkbox"/> negative	<input type="checkbox"/> positive
If anti-HCV test was positive, was a confirmatory test done?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
	If yes, results:	<input type="checkbox"/> negative	<input type="checkbox"/> positive

*HBsAg = hepatitis B surface antigen

^Anti-HBs = antibody to the hepatitis B surface antigen

‡Anti-HCV = antibody to hepatitis C virus

IV. Immunizations‡				
Vaccine	Vaccination Received Ever	Number of doses	Dates	Series completed?
Hepatitis A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	___/___/___ ___/___/___ ___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown
Hepatitis B	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	___/___/___ ___/___/___ ___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown
Hepatitis A/B	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	___/___/___ ___/___/___ ___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown

Human papilloma virus	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	____/____/____ ____/____/____ ____/____/____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown
Pneumococcal‡	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	____/____/____ ____/____/____ ____/____/____	
Influenza	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown		____/____/____ (most recent dose)	
Meningococcal ‡	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	____/____/____ ____/____/____	
Tetanus (Td)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	____/____/____ (most recent dose)	
Tetanus, diphtheria, pertussis (Tdap)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unknown	_____	____/____/____	

‡ please list all immunizations ever received

‡ includes both the conjugate and polysaccharide vaccines

V. Medication Use

A. Has patient ever taken antiretroviral therapy (ART)?

 yes no

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

 N/A Unknown

*please list the date first started on ART, which may not be the date the patient started on ART at *this* clinic

Is patient currently taking ART?

 yes no

If no, date of last use: ____/____/____

 N/A Unknown

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

B. Current ART Medications

Name of <u>Current</u> ART Medications*	Dosage (mg)	Frequency	Start date
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___

*Fixed dose combination medications (e.g. Atripla) should be listed on one line

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

Name of ALL <u>Former</u> ART Medications ever taken	Dosage (mg)	Frequenc y	Start date	Date discontinued	Reason for discontinuation
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure

					<input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____
			___/___/___	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> other _____

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

Name of <u>Current</u> Medication for OIs	Name of OI	Dosage (mg)	Frequency	Start date
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			___/___/___
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			___/___/___
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			___/___/___

	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			

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

Name of Former Medication for OIs	Name of OI	Dosage (mg)	Frequency	Start date	Date Discontinued
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__
	<input type="checkbox"/> treatment <input type="checkbox"/> prophylaxis			__/__/__	__/__/__

F. List other CURRENT medications

Names of Other Current Medications	Dosage (mg)	Frequency	Start date
			__/__/__

			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___
			___/___/___

VI. Current Medical History and Allergies

G. Please list all current medical problems including mental illnesses

Current Medical Problem List†

†please list each mental health diagnosis separately

H. Please list all known drug allergies

If patient has no known drug allergies please check the following box: no known drug allergies

Name of medication	Reaction to medication

VII. Tobacco, Drug and Alcohol use				
Is the patient a smoker?	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> no, but past use	<input type="checkbox"/> Unknown
If patient is a former smoker, how long ago did patient quit?	Years: _____	Months: _____	<input type="checkbox"/> Unknown	
If patient is a <i>present</i> or <i>past</i> smoker, what is the pack year smoked? Number of pack years = (packs smoked per day) × (years as a smoker)	_____		<input type="checkbox"/> N/A	
Does the patient use illegal drugs or abuse prescription controlled substances?				
Injection drug use	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> no, but past use	<input type="checkbox"/> Unknown
Non-injection drug use	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> no, but past use	<input type="checkbox"/> Unknown
Is patient currently or has patient ever been in a substance abuse treatment program?				
<input type="checkbox"/> N/A	<input type="checkbox"/> yes, currently in a program	<input type="checkbox"/> yes, in the past	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
If patient has ever been in a substance abuse treatment program, did patient complete the program?				
<input type="checkbox"/> N/A	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown	
Does the patient drink alcohol heavily? 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				
<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> no, but past use		<input type="checkbox"/> Unknown

If patient is a former heavy drinker, how long has patient been abstinent?	<input type="checkbox"/> N/A	Years: _____	Months: _____	<input type="checkbox"/> Unknown
Is patient currently or has patient ever been in an alcohol abuse treatment program?				
<input type="checkbox"/> N/A	<input type="checkbox"/> yes, currently in a program	<input type="checkbox"/> yes, in the past	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
If patient has ever been in an alcohol abuse treatment program, did they complete the program?				
<input type="checkbox"/> N/A	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown	

VIII. Clinic Appointment Information

Is patient new to this clinic or new to HIV care? yes 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.

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* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		

Medical visit* <input type="checkbox"/> ___/___/___ <input type="checkbox"/> yes <input type="checkbox"/> no Case management† <input type="checkbox"/> <input type="checkbox"/> Unknown Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/>	Medical visit* <input type="checkbox"/> ___/___/___ <input type="checkbox"/> yes <input type="checkbox"/> no Case management† <input type="checkbox"/> <input type="checkbox"/> Unknown Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/>
Medical visit* <input type="checkbox"/> ___/___/___ <input type="checkbox"/> yes <input type="checkbox"/> no Case management† <input type="checkbox"/> <input type="checkbox"/> Unknown Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/>	Medical visit* <input type="checkbox"/> ___/___/___ <input type="checkbox"/> yes <input type="checkbox"/> no Case management† <input type="checkbox"/> <input type="checkbox"/> Unknown Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/>

*a medical appointment with a physician, nurse practitioner or physician’s assistant

†appointment with Case management or a Social Worker

IX. Follow-up

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

date: ___/___/___ no appointment scheduled

When is patient’s first scheduled MTM appointment?

date: ___/___/___ no appointment scheduled

NOTES:

ADDITIONAL LABORATORY TEST VALUES

(use if there are more than four laboratory values in the past 12 to 24 months)

Please provide the following laboratory values for the past 24 months

Laboratory Test	Value/Date	Value/Date	Value/Date	Value/Date
CD4 (cells/ μ L and %)	_____ cells/ μ L	_____ cells/ μ L	_____ cells/ μ L	_____ cells/ μ L
	_____ %	_____ %	_____ %	_____ %
	____/____/____	____/____/____	____/____/____	____/____/____
HIV-1 RNA/DNA NAAT (Quantitative viral load) (copies/mL)	Copies/mL: _____	Copies/mL _____	Copies/mL _____	Copies/mL _____
	____/____/____	____/____/____	____/____/____	____/____/____
	____/____/____	____/____/____	____/____/____	____/____/____

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)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
LDL: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
HDL: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
TG: (mg/dL)	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____
HbA1c (only if diagnosed with diabetes):	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____	_____ ____/____/____

	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____
Glucose: (mg/dL)	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____
Hemoglobin:	_____	_____	_____	_____
LFTs (units/L)	ALT _____ AST _____ _____/____/____	ALT _____ AST _____ _____/____/____	ALT _____ AST _____ _____/____/____	ALT _____ AST _____ _____/____/____
Bilirubin (mg/dL)	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____
Creatinine	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____
Urinalysis	+ protein - protein _____/____/____	+ protein - protein _____/____/____	+ protein - protein _____/____/____	+ protein - protein _____/____/____
Was a basic chemistry panel completed?	Y / N _____/____/____	Y / N _____/____/____	Y / N _____/____/____	Y / N _____/____/____
HBV DNA (if HBV co-infected) (copies/mL)	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____	_____ _____/____/____
HCV RNA (if HCV co-infected)	_____	_____	_____	_____

(copies/mL)	____/____/____	____/____/____	____/____/____	____/____/____
Syphilis screening	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____	<input type="checkbox"/> negative <input type="checkbox"/> positive ____/____/____

ADDITIONAL CLINIC APPOINTMENT INFORMATION

(use if use if needed to record clinic appointment information)

Type of appointment	Date	Was appt. kept?	Type of appointment	Date	Was appt. kept?
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		
Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no	Medical visit* <input type="checkbox"/>	___/___/___	<input type="checkbox"/> yes <input type="checkbox"/> no
Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown	Case management† <input type="checkbox"/>		<input type="checkbox"/> Unknown
Mental Health <input type="checkbox"/>			Mental Health <input type="checkbox"/>		
Substance Abuse <input type="checkbox"/>			Substance Abuse <input type="checkbox"/>		

*a medical appointment with a physician, nurse practitioner or physician's assistant

†appointment with Case management or a Social Worker