

Patient Project ID: _____

Staff Project ID: _____

Clinic Project ID: _____

Form Approved

OMB No: 0920-XXXX

Exp. Date: XX/XX/XXXX

Quarterly Patient Information Form

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

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: (____) _____ - _____	<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:	

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 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? <input type="checkbox"/> no <input type="checkbox"/> yes	_____ cells/μL _____ % ___/___/___ <input type="checkbox"/> pending	_____ cells/μL _____ % ___/___/___ <input type="checkbox"/> pending	_____ cells/μL _____ % ___/___/___ <input type="checkbox"/> pending	_____ cells/μL _____ % ___/___/___ <input type="checkbox"/> pending
HIV-1 RNA/DNA NAAT (Quantitative viral load) (copies/mL) Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	Copies/mL: _____ ___/___/___ <input type="checkbox"/> pending	Copies/mL _____ ___/___/___ <input type="checkbox"/> pending	Copies/mL _____ ___/___/___ <input type="checkbox"/> pending	Copies/mL _____ ___/___/___ <input type="checkbox"/> pending

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? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
LDL: (mg/dL)	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
HDL: (mg/dL)	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
TG: (mg/dL)	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
HbA1c (only if diagnosed with diabetes):	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
Glucose: (mg/dL)	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
Hemoglobin:	_____	_____	_____	_____
Was lab drawn?	_____	_____	_____	_____

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

Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending
Syphilis screening Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> negative <input type="checkbox"/> positive ___/___/___ <input type="checkbox"/> pending	<input type="checkbox"/> negative <input type="checkbox"/> positive ___/___/___ <input type="checkbox"/> pending	<input type="checkbox"/> negative <input type="checkbox"/> positive ___/___/___ <input type="checkbox"/> pending	<input type="checkbox"/> negative <input type="checkbox"/> positive ___/___/___ <input type="checkbox"/> 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?	<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 been tested for anti-HBs^ since the last quarterly update?	<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 been tested for anti-HCV‡ since the last quarterly update?	<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

II. Medication Updates

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

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

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			__/__/__
			__/__/__
			__/__/__
			__/__/__
			__/__/__
			__/__/__
			__/__/__

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 NEW ART medications initiated since last quarterly update

Name of <u>new</u> ART medication	Dosage	Frequency	Start date
			__/__/__
			__/__/__
			__/__/__
			__/__/__
			__/__/__
			__/__/__

A3. List all DISCONTINUED ART medications since last quarterly update

Name of <u>discontinued</u> ART medication	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 _____

B1. Please list all other medications that the patient CURRENTLY 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 <u>discontinued</u> non-HIV medication	Date discontinued	Reason for discontinuation
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> other _____
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> other _____
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> other _____
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> other _____
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> other _____
	___/___/___	<input type="checkbox"/> tolerability <input type="checkbox"/> toxicity / side effects <input type="checkbox"/> failure <input type="checkbox"/> no longer indicated <input type="checkbox"/> 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?			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
If yes, how has smoking status changed?					
<input type="checkbox"/> N/A	<input type="checkbox"/> increased amount smoked	<input type="checkbox"/> decreased amount smoked			
<input type="checkbox"/> new smoker	Date started: ___/___/___	<input type="checkbox"/> quit smoking	Date quit: ___/___/___		
Has patient's illegal drug use/abuse of prescription controlled substances changed since last quarterly update?			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
If yes, how has drug abuse status changed?					
<input type="checkbox"/> N/A	<input type="checkbox"/> increased amount used	<input type="checkbox"/> decreased amount used			
<input type="checkbox"/> new user	Date started: ___/___/___	<input type="checkbox"/> quit using	Date quit: ___/___/___		
Has patient initiated or completed substance abuse treatment since last quarterly update?					
<input type="checkbox"/> N/A	<input type="checkbox"/> yes, currently in a	<input type="checkbox"/> yes, completed a	<input type="checkbox"/> no	<input type="checkbox"/> 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			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Unknown
If yes, how has alcohol consumption changed?					
<input type="checkbox"/> N/A	<input type="checkbox"/> increased drinking		<input type="checkbox"/> decreased drinking		
<input type="checkbox"/> new heavy drinker	Date started: ___/___/___	<input type="checkbox"/> quit drinking	Date quit: ___/___/___		
Has patient initiated or completed alcohol abuse treatment since last quarterly update?					
<input type="checkbox"/> N/A	<input type="checkbox"/> yes, currently in a program	<input type="checkbox"/> yes, completed a program	<input type="checkbox"/> 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* <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"/>
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

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?
___/___/___	<input type="checkbox"/> fax <input type="checkbox"/> in person <input type="checkbox"/> other _____	<input type="checkbox"/> yes date: ___/___/___ <input type="checkbox"/> no <input type="checkbox"/> unknown

____/____/____	<input type="checkbox"/> fax <input type="checkbox"/> in person <input type="checkbox"/> other _____	<input type="checkbox"/> yes date: ____/____/____ <input type="checkbox"/> no <input type="checkbox"/> unknown
____/____/____	<input type="checkbox"/> fax <input type="checkbox"/> in person <input type="checkbox"/> other _____	<input type="checkbox"/> yes date: ____/____/____ <input type="checkbox"/> no <input type="checkbox"/> unknown
____/____/____	<input type="checkbox"/> fax <input type="checkbox"/> in person <input type="checkbox"/> other _____	<input type="checkbox"/> yes date: ____/____/____ <input type="checkbox"/> no <input type="checkbox"/> unknown
____/____/____	<input type="checkbox"/> fax <input type="checkbox"/> in person <input type="checkbox"/> other _____	<input type="checkbox"/> yes date: ____/____/____ <input type="checkbox"/> no <input type="checkbox"/> 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:

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/ μ L and %)	_____ cells/ μ L _____ %	_____ cells/ μ L _____ %	_____ cells/ μ L _____ %	_____ cells/ μ L _____ %
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
HIV-1 RNA/DNA NAAT (Quantitative viral load) (copies/mL)	Copies/mL: _____	Copies/mL _____	Copies/mL _____	Copies/mL _____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> 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? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
LDL: (mg/dL)	_____	_____	_____	_____
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
HDL: (mg/dL)	_____	_____	_____	_____

Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
TG: (mg/dL)	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
HbA1c (only if diagnosed with diabetes):	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
Glucose: (mg/dL)	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
Hemoglobin:	_____ <input type="checkbox"/> pending	_____ <input type="checkbox"/> pending	_____ <input type="checkbox"/> pending	_____ <input type="checkbox"/> pending
LFTs (units/L)	ALT _____ AST _____ ____/____/____ <input type="checkbox"/> pending	ALT _____ AST _____ ____/____/____ <input type="checkbox"/> pending	ALT _____ AST _____ ____/____/____ <input type="checkbox"/> pending	ALT _____ AST _____ ____/____/____ <input type="checkbox"/> pending
Bilirubin (mg/dL)	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
Creatinine	_____	_____	_____	_____

Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
Urinalysis	+ protein - protein	+ protein - protein	+ protein - protein	+ protein - protein
Was lab done? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending
Was a basic chemistry panel completed?	Y / N ____/____/____ <input type="checkbox"/> pending	Y / N ____/____/____ <input type="checkbox"/> pending	Y / N ____/____/____ <input type="checkbox"/> pending	Y / N ____/____/____ <input type="checkbox"/> pending
HBV DNA (if HBV co-infected) (copies/mL)	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending
HCV RNA (if HCV co-infected) (copies/mL)	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending	_____ ____/____/____ <input type="checkbox"/> pending
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending	<input type="checkbox"/> pending
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
Was lab drawn? <input type="checkbox"/> no <input type="checkbox"/> yes	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending	____/____/____ <input type="checkbox"/> pending

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* <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

Patient Project ID: _____

Staff Project ID: _____

Clinic Project ID: _____