Form Approved

OMB No: 0920-1019

Exp. Date: 08/31/2018

Integrating Community Pharmacists and Clinical Sites

for Patient-Centered HIV Care

**Attachment 7a 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 (0920-1019)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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?**□ 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  |

**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-HCVǂ 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

**ǂ**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 current *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 NEW ART medications initiated since last quarterly update**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of new *ART* medication**  | **Dosage** | **Frequency** | **Start date** |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |

**A3. List all discontinued ART medications since last quarterly update**

|  |  |  |
| --- | --- | --- |
| **Name of discontinued *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 currently takes (at the time of quarterly update)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of other current 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 program | □ yes, completed a program | □ no | □ Unknown |
| **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\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ 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 □ |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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)****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 |

**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\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ 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 □ |
| 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