Acquired Immune Deficiency Syndrome (AIDS)
PHYSICIAN REFERRAL FOR INDIVIDUALS AT RISK OF HOSPITALIZATION

Incomplete forms will be returned. Please complete all items. If non-applicable please indicate with N/A. Attach extra sheets or supporting documentation if necessary.

Name: _____ ***SSN#**: _____ DOB: _____

1. AIDS Diagnosis (initial if yes): _____ (Please include opportunistic infections on reverse)

2. CD4 count _____% _____ Viral Load _____ as of _____ (Date)
(Percentage) (Absolute)

Defining AIDS without opportunistic infection: CD4 Absolute count of less than 200 OR
CD4 Percentage of less than 14

3. Medications (please list all prescribed medications):

4. All body systems have been reviewed and specific physical findings are checked below.

___	Vision and Hearing	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Respiratory	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Gastrointestinal	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Genito-Urinary	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Cardiovascular	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Musculoskeletal	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Neurological	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment

5. Medical History Significant to Home Based Care: _____

_____

_____

6. Treatment & Therapies: Please check all that apply.

___ Physical Therapy ___ Occupational Therapy ___ Respiratory Therapy
___ Substance Abuse Treatment ___ Massage Therapy ___ Other
Other: _____

7. Diet: _____

_____

8. Prognosis: ___ Good ___ Fair ___ Poor Rehabilitation Potential: ___ Good ___ Fair ___ Poor

9. Unmet Home Based Care Needs: _____

_____

_____

***WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)?** Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

OVER-SIDE 2 MUST BE COMPLETED

OPPORTUNISTIC INFECTIONS

BACTERIAL INFECTIONS

____ Mycobacterial Infections
____ Nocardiosis
____ Salmonella Bacteremia
____ Syphilis or Neurosyphilis
____ Multiple Bacterial Infections

PROTOZOAN OR HELMINTHIC INFECTIONS

____ Cryptosporidiosis
____ Isosporiasis
____ Microspondiosis
____ Pneumicystis Carinii Pneumonia
____ Extrapulmonary Carinii Infection
____ Stongyloidiasis, Extra-Intestinal
____ Toxoplasmosis

FUNGAL INFECTIONS

____ Aspergillosis
____ Candidiasis
____ Coccidioidomycosis
____ Cryptococcosis
____ Histoplasmosis
____ Mucormycosis

MALIGNANT NEOPLASMS

____ Cervical Cancer, Stage II+
____ Kaposi's Sarcoma with Wide-spread Involvement
____ Lymphoma
____ Squamous Cell Carcinoma of the Anus

HEMATOLOGIC DISORDERS

____ Anemia
____ Granulocytopenia
____ Thrombocytopenia

VIRAL INFECTIONS

____ Cytomegalovirus Disease
____ Herpes-Simplex-Mucocutaneous
____ Herpes Zoster
____ Progressive Multifocal Leukoencephalopathy
____ Hepatitis

OTHER COMPLICATIONS

____ HIV Wasting Syndrome
____ Chronic Diarrhea
____ Chronic Weakness
____ Cardiomyopathy
____ Nephropathy
____ Sepsis
____ Meningitis
____ Pneumonia
____ Endocarditis
____ Septic Arthritis
____ Peripheral Neuropathy
____ HIV Encephalopathy/Dementia

10. Other: Repeated manifestations of HIV infection resulting in significant, documented symptoms of one or more of the following:

___ Restrictions in activities of daily living (ADL)s (Check all that apply):

Ambulation ___ Transfer Skills ___ Eating Skills ___ Dressing Skills ___ Personal Hygiene Skills ___

Specify other ADL restrictions: _____

_____

__Restrictions in Maintaining Social Functioning (Inability to interact appropriately and communicate effectively with others.)

__Difficulties in Completing and Maintaining Tasks in a Timely Manner Due to Deficiencies in Concentration, Persistence, or Pace (Cannot perform these activities due to fatigue or effects of medication on concentration and coordination.)

Specify other mental or physical limitations: _____

_____

11. Do you believe the client is a danger to self and/or others? YES _____ NO _____

Comments: _____

Based on the patient's medical history and current condition, I certify that this individual is disabled and I believe there is reasonable indication that this individual might be at continual risk of hospitalization in the absence of home and community-based services.

12. Physician's Signature: _____ Date: _____

Physician's Name: _____ License #: _____

Address: _____ Telephone: _____