DATE: _____ SEVERITY LEVEL _____

PHC Initial Care Management Assessment

Client Contact Information – Section A		
First Name:	Last Name	DOB:
SS#:	MediPass #:	Recipient ID#:
AHCA Address:		
City:	Zip:	County:
Primary Address:		
City:	Zip:	County
Mailing Address:		
City:	Zip:	
Home Phone:	Cell Phone:	Pager:
Work Phone:	FAX:	E-Mail:
AHCA Supplied Address Correct: □ YES □ NO	AHCA Correction Sent: □ YES □ NO	Date:

Alternative Contact/ Healthcare Consent Information – Section B	
Emergency Contact Person:	Relationship:
Address:	City/State/Zip
Aware of HIV Status: □ YES □ NO	Phone:
Advance Directive Information Supplied: □ YES □ NO	Comment:
Durable Power of Attorney for Healthcare: □ YES □ NO	Living Will: □ YES □ NO
Designated Person:	Relationship:
Address:	City/State/Zip
Aware of HIV Status: □ YES □ NO	Phone:
Physician has a copy: □ YES □ NO	

Client Demographic Information – Section C

✔	Marital Status	✔	Race	✔	Gender	✔	Housing
	Single		Caucasian		Male		Alone
	Married		African American		Female		With Spouse
	Widowed		Haitian		Transgender M>F		Spouse and Children
	Separated		Hispanic		Transgender F>M		Blood relative
	Divorced		Native American	✔	**Sexual Orientation**		Domestic Partner
	Domestic Partner		Pacific Islander		Heterosexual		Group Home
	Other:		Asian		Bisexual		Shelter
✔	**Dependents**		Other:		Gay		Homeless
	Children	✔	**Primary Language**		Lesbian		Skilled Nursing Facility
	Age:_____ Sex:_____		English	✔	**Risk Category**		Shared/Roommate
	Age:_____ Sex:_____		Spanish		Decline to state	✔	**Education**
	Age:_____ Sex:_____		Creole		Transfusion		None
	Age:_____ Sex:_____		French		Hemophiliac		K-6th
	Age:_____ Sex:_____		Other:		IVDU		7-12
	Mother	✔	**Written Materials**		MSM		Some College
	Father		English		MSM/IVDU		College Graduate
	Sibling		Primary Language		Sex Worker		Post Graduate
	Domestic Partner		Braille		Mother/Child Transmission	✔	**Income**
	Other		Non-Reader		Heterosexual		None
✔	**Support System**	✔	**Mailings**	✔	**Safer Sex**		<$10,000
	Family		All materials OK		Condoms Always		>$10K <$20K
	Friends		Thrive Only		Condoms Mostly		>$20K <$30K
	Church		Education/PHC		Condoms Sometimes		>$30K <$40K
	ASO:		No Mail		Condoms Never		Other

Social Demographics

EMPLOYMENT INFORMATION – Section D

Occupation:	Employed: ☐ YES ☐ NO ☐ CASH	
Employer:		Hours Worked per week:
Address		Phone
City	County	Zip
Health Benefits: ☐ YES ☐ NO	Commercial Health Plan:	
Disabled: ☐ YES ☐ NO	Date Disabled:	Applied for SSDI: ☐ YES ☐ NO

LIVING ENVIORNMENT – Section E

✔	Dwelling	✔	Dwelling	Number of persons in the household:		
	☐ Own ☐ Rent ☐ HOPWA ☐ Other			Question	Yes	No
	Single family dwelling		Rehab Center	Do other household members know HIV Status?		
	Condominium		ACLF	Who:		
	Apartment		Hotel	Other in home HIV Positive?		
	Room			Who:		
	Shelter			Caregiver available if necessary		
	Nursing Facility			Who:		

✔	Pets	Relationship:	Phone
	Dog #		
	Cat #		
	Bird #		
	Reptile #		
	Other &#		

✔	Utilities	✔	Appliance	✔	Transportation
	Running Water		Stove		Car
	Electricity		Refrigerator		Family/Friends
	Gas		Air Cond		Bus
	Phone		Microwave		Other
					Other
	VCR		DVD		Cassette Player
	CD Player				Computer

Who Cleans up:	
Home Communication Media: (Equipment for education materials)	

SOCIAL SERVICE/ANCILLARY HEALTH PROVIDERS – Section F

ASO Name:		Phone:
Address:		
City	County	Zip
ASO Case Manager:		
ASO CM Phone:	ASO CM e-mail:	ASO CM Other:

PAC Waiver Services – Section G

	Adult Dental		Homemaker		Specialized Care Foster Child
	Case Management		Nutritional Risk Reduction		Other
	Chore – Pest Control		Personal Care		Other
	Chore - Other		Skilled Nursing – RN/LPN		
	Day Health Care		Specialized Medical Equipment		
	Education and Support		Medical Supplies		
	Environmental Adaptations		Therapeutic Mgmt Substance		
	Home Delivered Meals		Restorative Massage		

Assistance Benefits – Section H

	Cash Assistance		OSS		Private disability
	SSI		Unemployment		ADAP
	Medicaid		Medicare		Veterans Medical
	Indian Medical Services		Food Stamps		Veterans Pension
	Private Retirement		Life Insurance		Insur. Continuation (ICAP)

Assistance Benefits Detail – Section I			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			

Mental Health/Life Habits Information – Section J		
Are you currently seeing a mental health provider?	YES:	NO:
Type of provider: ☐ Psychiatrist ☐ Psychologist ☐ LCSW ☐ MFCC ☐ MSW ☐ Group ☐ Other:		
Provider Name:	Phone	
Address:	City:	Zip
E-mail:	Access to Chart: ☐ YES ☐ NO	

Symptoms					
Are you currently experiencing any of the following: (check if present)					Increased sadness?
	Increased tearfulness?		Sleep disturbance?		Feeling of helplessness/hopelessness
	Decrease sex drive?		Loss/decrease energy?		Loss of interest in usual/favored activities
	Low self esteem?		Difficulty concentrating?		Feelings of guilt?
If client is experiencing 5 or more of these symptoms, he/she may be depressed. Contact PCP for Mental Health referral.					

✔	Current Therapy For –Section K				
	Anxiety		Bipolar		Substance Abuse
	Depression		Panic Disorder		OCD
	Grief		Schizophrenia		Other:

Comment:

Exercise – Section L

✔	Exercise Routine	Frequency	Duration
	None		
	Walking		
	Bike Riding		
	Aerobic		
	Weight Training		
	Swimming		
	Jogging		
	Calisthenics		
	Other:		
	Other:		

Diet and Nutrition - Section M

Current Weight:	Height:	Ideal Body Weight:
Recent Weight Loss/Gain: ☐ Yes ☐ No	Amount Loss/Gain:	Period of time:
Intentional Loss/Gain: ☐ Yes ☐ No	Comment:	

Body Fat/Bone Density Measurement – Section N

"	Waist	"	R Upper Arm	"	Abdomen	"	R Thigh
"	Hips	"	L Upper Arm	"		"	Facial Wasting
"	Chest	"	L Thigh	"		"	"Buffalo Hump"

BIA Done: ☐ Yes ☐ No	BIA Result:	Date BIA Done:
Bone Density Done: ☐ Yes ☐ No	BD Result:	Date BD Done:

Diet – Section O

Special Diet: ☐ Yes ☐ No	Diet Type:
Restrictions:	
Supplements Taken: ☐ Yes ☐ No	Supplement Type:

Vitamins/Minerals Taken:	Frequency:
Vitamins/Minerals Taken:	Frequency:
Vitamins/Minerals Taken:	Frequency:
Herbals Taken:	Frequency:
Herbals Taken:	Frequency:
Herbals Taken:	Frequency:

Food Allergies:

Usual Water per day: ☐ 1-3 glasses ☐ 4 – 6 glasses ☐ 7- 9 glasses ☐ 10 – 12 glasses ☐ None

Comments:

Activities of Daily Living – Section P						
Activity	**Independent**	**Minimal Assist**	**Maximum Assist**	**Dependent**	**PAC Waiver**	**Comment**
Bathing						
Oral Hygiene						
Toileting						
Grooming						
Dressing						
Ambulate						
Cook						
Feed Self						
Use Phone						
Clean Home						
Drive						
Use Public Transportation						
Transfer self- bed/chair, chair/car, etc.						
Pay bills						
Grocery Shop						
Sight						
Hearing						
Reading						
Speech						
Medication Administration						
Medical Testing (eg. BGM, B/P)						
Medical Treatment (eg. Dressings, etc.)						
Child Care						
Fill Out Forms						
Other:						

Section #	Comments Related to Information Collected

Medical/Ancillary Health Provider Information – Section Q			
MediPass Primary Care Provider			
Primary Care Provider:			Category: MD, DO, RNP, PA
Address			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing MediPass PCP: ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Attending Provider			
"Attending Provider"			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Specialty Medical Provider(s)			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:		Access to Medical Record: ☐ YES ☐ NO	
Additional Medical Provider			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Dental Care Provider			
Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:	Reason:	
Frequency of visits:			
Comment:		Access to Medical Record: ☐ YES ☐ NO	

Medical/Ancillary Health Provider Information – Section Q Continued			
Ancillary Health Provider			
Name:			
Type: ☐Home Health Skilled Nursing ☐ Physical Therapy ☐ Respiratory Therapy ☐ Other:			
Address			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing: ☐ YES ☐ NO	Last Visit:		
Reason for Last Visit:			
Comment:	Access to Medical Record: ☐ YES ☐ NO		
Ancillary Health Provider			
Name:			
Type: ☐Home Health Skilled Nursing ☐ Physical Therapy ☐ Respiratory Therapy ☐ Other:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:		
Reason for Last Visit:			
Comment:	Access to Medical Record: ☐ YES ☐ NO		
Pharmacy			
Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: ☐ YES ☐ NO	Last Fill:		
Refills all on same schedule: ☐ YES ☐ NO	Do you call for Refills?: ☐ YES ☐ NO		
Are Refills Done Automatically by Pharmacy: ☐ YES ☐ NO	Pharmacist Name:		
Access to Pharmacy Profile: ☐ YES ☐ NO Comment:			
Payer Source: ☐ Medicaid ☐ ADAP ☐ Veterans ☐ Indian Affairs ☐ Private Plan ☐ Cash ☐ Other			
Comment:			
Additional Pharmacy			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: ☐ YES ☐ NO	Last Fill:		
Refills all on same schedule: ☐ YES ☐ NO	Do you call for Refills?: ☐ YES ☐ NO		
Are Refills Done Automatically by Pharmacy: ☐ YES ☐ NO	Pharmacist Name:		
Access to Pharmacy Profile: ☐ YES ☐ NO Comment:			
Payer Source: ☐ Medicaid ☐ ADAP ☐ Veterans ☐ Indian Affairs ☐ Private Plan ☐ Cash ☐ Other			
Comment:			
Other Ancillary Health Provider			
Name:		Type:	
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:	Reason:	
Comment:	Access to Medical Record: ☐ YES ☐ NO		

MEDICAL HISTORY – Section R

ALLERGIES:

HIV History

First HIV Positive Date:		Source: ☐ Client Self Report ☐ Medical Record	
Most Recent Viral Load Date:	Result:	Most Recent CD4 Date:	Result:
Highest VL Date:	Result:	Lowest CD4 Date:	Result:

Source = C (Chart) P (Patient Reports) **Opportunistic Diseases and/or Complications**

Source	Onset ✔	Resolved ✔	Condition	Source	Onset ✔	Resolved ✔	Condition
			Pneumocystis carinii pneumonia (PCP)				HIV Encephalopathy
			Esophageal Candidiasis				Other neuro manifestations, eg. Peripheral neuropathy
			Kaposi's Sarcoma				Cardiomyopathy (CHF or cor pulmonale or other abn. Not responsive to treatment
			HIV wasting disease (>10% wt loss)				Nephropathy resulting in chronic renal failure
			Mycobacterium avium complex (MAC)				Infections resistant to treatment/requiring hospitalization or IV's 3x/year (e.g. sepsis,menigitis, pneumonia, septic arthritis, endocarditis, sinusitis)
			Cytomegalovirus disease (eyes)				Anemia (Hct @30% or <
			Cytomegalovirus disease (GI)				Granulocytopenia ANC < 1000 recrurrent bacterial infection 3x in 5 mo
			Cytomegalovirus disease (Disseminated)				Cancer of Cervix, invasive FIGO Stage II and >
			AIDS Dementia Complex				Thrombocytopenia Platelets<40K repeatedly with spontaneous bleed
			Cryptococcosis				Diarrhea lasting > 1 mo, resistant to treatment
			Non-Hodgkin's lymphoma				Cholesterol abnormalities
			Toxoplasmosis				Triglyceride abnormalities
			Cryptosporidiosis				Diabetes
			Chronic herpes simplex infection				Insulin resistance
			Recurrent bacterial pneumonia				Fat Maldistribution
			Tuberculosis				Osteoporosis
			Multiple vaginal infections				Osteopenia
			PML				Osteomalacia
			Cholesterol abnormalities				Lactic Acidosis
			Aspergillosis				Pancreatitis
			Histoplasmosis				Microsporidiosis
			Isosporiasis				Strongyloidiasis (extra-intestinal)
			Other:				Other:

CDC AIDS Case Definition Categories

✔	CD4 Cell Categories	✔	**A:** Asymptomatic or PGL or Acute HIV Infection	✔	**B:** Symptomatic (not A or C)	✔	**C:** AIDS Indicator Condition
	1. > 500/mm³ (29%)		**A1**		**B1**		**C1**
	2. 200 to 499/ mm³ (14% to 28%)		**A2**		**B2**		**C2**
	3. <200/ mm³ (14%)		**A3**		**B3**		**C3**

*** All patients in categories A3, B3, and C1-3 are defined as having AIDS based on the presence of an AIDS indicator condition and/or a CD4 cell count < 200/mm³**

ARV THERAPY HISTORY

Currently taking ARV Regimen: ☐ YES ☐ NO	**IF NO, WHY?:** ☐ Refused ☐ CD4> 500
☐ CD4 > 350, VL < 55,000(PCR) or <33,000 (b DNA)	☐ Other:

ARV THERAPY HISTORY								
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**NRTIs**		**Dose**	**Frequency**	**DC Reason**
				Zidovudine	Retrovir (AZT)			
				Didanosine	Videx (ddI)			
				Zalcitabine	Hivid (ddC)			
				Stavudine	Zerit (d4T)			
				Lamivudine	Epivir (3TC)			
				Abacavir	Ziagen (ABC)			
				Combivir	AZT + 3TC			
				Trizivir	AZT+3TC+ABC			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**NNRTIs**		**Dose**	**Frequency**	**DC Reason**
				Nevirapine	Viramune (NVP)			
				Delavirdine	Rescriptor (DLV)			
				Efavirenz	Sustiva (EFV)			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**PROTEASE INHIBITORS**		**Dose**	**Frequency**	**DC Reason**
				Indinavir	Crixivan (IDV)			
				Ritonavir	Norvir (RTV)			
				Saquinavir	Invirase, Fortovase (SQV)			
				Nelfinavir	Viracept (NFV)			
				Amprenavir	Agenerase (APV)			
				Lopinavir/ritonavir	Kaletra (ABT/378/R, LPV/RTV)			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**INVESTIGATIONAL DRUGS**		**Dose**	**Frequency**	**DC Reason**
				NRTI	Emtricitabine	200mg	QD	
				NRTI	DAPD	300-500 mg	BID	
				NRTI	Tenofovir	300mg	QD	
				NNRTI	Capravirine	700-1200 mg	BID	
				NNRTI	TMC120	50-100 mg	BID	
				PI	BMS-232632	200-500 mg	QD	
				PI	Tipranavir	300-1200mg + 200mg Ritonavir		
				BFI*	T-20	50-100 mg	BID	
				BFI*	T-1249	6.25-50 mg	QD or BID	
				BFI*	PRO 542	0.2 10.0 mg/kg IV		

*** BFI = Binding/ Fusion Inhibitors**

PRIMARY INVESTIGATOR IF ON INVESTIGATIONAL DRUGS	
P.I. Name:	
Study:	
Study Location:	
Study Coordinator:	**Phone:**

PROPHYLACTIC MEDICATIONS				
Start	**Stop**	**Medication**	**Recommendations**	**Disease Prevention**
		TMP/SMX 1DS/day or 1 SS/day or 3DS/week	<200-250 CD4	PCP
		Fluconazole 100-200mg/day PO	High risk pt with <50 CD4	Crypto, Coccidio
		TMP/SMX 1 DS/day PO	+ Toxo IgG with CD4<100	Toxoplasmosis
		Cytovene 1 g PO tid	<50 CD4	CMV
		Clarithromycin 500 mg qd or bid	<50 CD4	MAC

NON-ARV MEDICATION PROFILE							
Start	**Stop**	**MD RX**	**Filled**	**Medication**	**Dose**	**Frequency**	**DC Reason**

MEDICAL HISTORY					
✔	**Co-morbid Conditions**	✔	**Co-morbid Conditions**	✔	**Co-morbid Conditions**
	Abnormal PAP		Diabetes Type I		OCD
	Anemia		Diabetes Type II		Paralysis
	Anxiety:		Eczema		Psoriasis
	Arthritis		Erectile dysfunction		Schizophrenia
	Asthma		ETOH Use		Seizures
	Bronchitis		GERD (Gatroesoph Reflux)		Sleep problems
	CHF		Hepatitis A		Smoking:
	Cirrhosis		Hepatitis B		Thyroid abnormalities
	Constipation		Hepatitis C		TMJ
	COPD		Hypertension		Urinary Incontinence
	Depression		Kidney Failure		Vaginal Bleeding
Other Medical History Conditions:					

SYSTEM REVIEW HISTORY – Section S						
Vital Signs	B/P:	P:	R:	T:	Weight:	Height:
Head & Neck						
Eyes						
Chest & Lungs						
Cardiovascular						
Breast						
Pelvic						
Abdominal (GI)						
Kidney & Urinary						
Back & Extremity						
Neurologic						
Mental Status						
Oral/Dental						
Other System History Information:						

GYN HISTORY – Section T			
LMP:	Gravida:	Para:	Births since HIV+:
HIV + Children:		Desire Children:	
Last PAP Smear Date:		Results:	
Birth Control Method: ☐ Rhythm Method ☐ Barrier ☐ Birth Control Pills ☐ Abstinence ☐Other:			
Menopause Onset Date:		Estrogen Replacement:	

IMMUNIZATION HISTORY – Section U			
Date	**Immunization**	**Date**	**Immunization**
	Dip Tet		Pneumococcal CD4 when given:
	MMR		Influenza
	Polio		Varicella
	Hepatitis B		Other:
	Hepatitis A		Other:

SUBSTANCE USE HISTORY – Section V				
✔	**Substance**	**Amount**	**Frequency**	✔ **if currently using**
	Alcohol*			
	Opiates			
	Marijuana			
	Cocaine/Crack			
	Speed/Amphetamines			
	PCP			
	GHB			
	Ecstacy*			
	Methadone			
	Fentenyl Patch			
	OxyContin			
	Crystal Meth			
	"Special K" *			
	Other:			
* Significant drug/drug interaction with PIs.				
If actively using, is client interested in stopping? ☐ YES ☐ NO				

LIVER DISEASE HISTORY – Section W			
Hepatitis B			
Have you had Hepatitis B: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:			
Test	**Date**	**Result** **Positive ✔ / Negative ✔**	**Source of Info** **Chart ✔ / Patient ✔**
Anti-HBc (Hepatitis B Core Antibody)			
Anti-HBs (Hepatitis B Surface Antibody)**			
HBsAg (Hepatitis B Surface Antigen)			
** If recently vaccinated, Anti-HBs needs to be done 1 to 6 months after the last dose of vaccine.			

Hepatitis B Vaccine					
Date Given	**Vaccine**	**Date Due**	**Date Given**	**Vaccine**	**Date Due**
	Hepatitis B Vaccine 1cc dose #1			Hepatitis B 1cc dose #3	
	Hepatitis B Vaccine 1 cc dose #2			HbsAb Test to verify	

Hepatitis B Treatment History					
Start Date	**Stop Date**	**Treatment**	**Result**	**Source of Info Chart ✔ / Patient ✔**	
		Epivir 150 mg bid (HIV) or 100mg/day (HBV)			
		Interferon 30-35 mil units/wk x 4 mo			
		HARRT therapy with no anti-HBV agents			
		Nothing			
		Other:			
		Epivir+ famciclovir 500mg bid or tid to decrease resistance to Epivir. *(Experimental)*			

Hepatitis C						
Do you have Hepatitis C: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:						
Test	**Date**	**Approximate $**	**Result Positive ✔ / Negative ✔**		**Source of Info Chart ✔ / Patient ✔**	
EIA for Anti-HCV		25 – 45				
RIBA for Anti-HCV		115 – 150				
RT-PCR for HCV RNA		160 – 200				
HCV PCR (Quantitative RNA)		160 – 225				
Genotype		200 – 250				

Hepatitis C Treatment History					
Start Date	**Stop Date**	**Treatment**	**Result**	**Source of Info Chart ✔**	**Patient ✔**
		Hepatitis A vaccine if HAV sero-negative			
		Alpha interferon, 3 million units SC 3x/wk plus Ribavirin 1000 – 1200 mg/day PO x 24 wks for genotype 2&3 or 48 wks for genotype 1			
		Peginterferon alfa 2, or alpha 2b (PEG-Intron), 1.0-1.2 mg/kg q wk SC; both should be combined with ribavirin 10.6 mg/kg/day x 48 weeks			
		Nothing			
		Other:			

Hepatitis A					
Have you had Hepatitis A: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:					
Test	**Date**	**Result Positive ✔ / Negative ✔**		**Source of Info Chart ✔ / Patient ✔**	
Anti-HAV (IgG)					

Hepatitis A Prophylaxis History			
Date Given	**Treatment**	**Chart ✔**	**Patient ✔**
	Havrix 0.5 mL IM x 2 separated by 6 months		
	Havrix 0.5 mL IM second dose		

PAIN HISTORY – Section X						
Question	**Yes**	**No**	✔	**Pain Characteristics**	✔	**Pain Characteristics**
Do you currently have pain?				Constant		Dull, aching
Pain Scale		**#**		Intermittent		Burning
Scale of 1-10, 10 being worst:				Sharp		Tingling
Location of Pain:				Stabbing		Numbness

PAIN MEDICATIONS				
✔	Medication	Dose	Frequency	Effective ✔
	ASA, Acetominophen			
	Codeine			
	Demerol			
	Dilaudid			
	Methadone			
	MS Contin			
	OxyContin			
	Fentanyl Patch			
	Ultram			
	NSAIDS			
	Neurontin			
	Lortab:			
	Vicodin:			
	Other:			
	Other:			

Sexually Transmitted Diseases – Section Y							
Onset	Treated	Resolved	Infection	Onset	Treated	Resolved	Infection
			Syphilis				Chancroid
			Gonorrhea				Herpes
			LGV (Lymphogranuloma venerium)				Rectal Warts
			HPV (Genital Warts)				Trichomonas
			Condyloma				Other
			Chlamydia				Other
STD Comments:							

Prosthesis and/or Implanted Devices							
✔		✔		✔		✔	
	Hearing Aid		PortaCath		Pacemaker		
	Glasses		Triple lumen catheter				
	Dentures		PICC line				

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									Write in Lab Name on this line
Test	Date	Result	Date	Result	Date	Result	Date	Result	Recommend Frequency
HIV Ab									Initial
CD4 Absolute									Q 3 to 6 MONTHS
CD4 %									Q 3 to 6 MONTHS
Viral Load									Q 3 to 6 MONTHS
Hemoglobin									Q 3 to 6 MONTHS
Hematocrit									Q 3 to 6 MONTHS

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									**Write in Lab Name on this line**
Test	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Recommend Frequency**
WBC									Q 3 to 6 MONTHS
RBC									Q 3 to 6 MONTHS
Platelets									Q 3 to 6 MONTHS
ANC									Q 3 to 6 MONTHS
K									Initial and PRN as appropriate
Na									Initial and PRN as appropriate
Cl									Initial and PRN as appropriate
CO2									Initial and PRN as appropriate
FBS									2 mo. After starting PI and q 3 to 4 months
BUN									
Creatinine									
Bilirubin									
AST									Base & 24 wks after initiation of tx
ALT									Base & 24 wks after initiation of tx
Albumin									Base & 24 wks after initiation of tx
Alk Phos									Base & 24 wks after initiation of tx
GGT									Base & 24 wks after initiation of tx
Lipase									Per Symptoms
Amylase									Per symptoms
Lactic Acid									Per Symptoms
VDRL/RPR									Q Year or PRN by history
LDH									Per Symptoms
CPK									Per Symptoms
Cholesterol									Base and Q 3 to 6 Mo

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									**Write in Lab Name on this line**
Test	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Recommend Frequency**
LDL									Base and Q 3 to 6 Mo
HDL									Base and Q 3 to 6 Mo
Triglycerides									Base and Q 3 to 6 Mo
PAP Smear									Q 6 months
PPD TB Test									Annual if previous neg
CXR									Per Sx or new + PPD
CMV IgG									Optional baseline, when sx
Toxoplasma IgG									Base screen. Repeat if <100 CD4 or symptomatic
Genotype									Suspected resistance
Phenotype									Suspected resistance
ARV Drug Level: _____									Suspected resistance
G6PD									Baseline for risk population
Hgb A1c									
INR									

INITIAL ASSESSMENT	
Section if applicable	**CARE MANAGER COMMENTS**

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
	Marital Status					
	Single					
	Married					
	Widowed					
	Separated					
	Divorced					
	Domestic partner					
	Dependents (Select only 1 answer)					
	No Dependents					
	Children over 18					
	Children > 5 years at home					
	Children < 5 years at home					
	Support System (Select those that apply)					
	Alone - no friends or family					
	Lives alone some friends					
	Lives alone family close by					
	Lives with friends/family--no support					
	Lives with friends/family--adequate support					
	Others in the home **Do Not** know of HIV status					
	Housing (Select only 1 answer)					
	Lives alone apartment or house					
	Lives with others--permanent					
	Lives with others--temporary					
	Lives at a shelter					
	Lives in a supervised facility					
	Homeless					
	Utilities (Select all that apply)					
	No Phone					
	No Water					
	No Gas--if needed for cooking or hot water					
	No electricity					
	Appliances (Stove/Refrigerator)					
	Missing stove					
	Missing refrigerator/freezer					
	Transportation (Select only 1 answer)					
	Dependant on Bus/Taxi					
	Has own transportation					
	Has third party funded transportation					
	Has access to transportation--family/friend					
	Unable to Access Public Transportation					

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
	Income					
	None					
	<10K income and or benefits					
	10K--20K income and benefits					
	>20K in income and benefits					
	Employment (Select all that apply)					
	Employed (Part-time or Full-time)					
	Unemployed					
	Disabled					
	Benefits (Select only 1 answer)					
	No benefits					
	1--2 benefits					
	3--6 benefits					
	> 6 benefits					
	Education (Select all that apply)					
	None					
	K-6					
	7-12					
	> 12 years of school					
	reads and writes English					
	reads and writes another language					
	does not read or write any language					
	No Mailings					
	Language (Select only 1 answer)					
	Primary language is English					
	English as a second language (ESL)					
	Does not speak English					
	Mental Health Risk					
	Exhibits mental health challenges--not in care					
	Exhibits mental health challenges--in care					
	No mental health issues apparent					
	Refuses mental health care					
	Health Risk Behaviors (Select all that apply)					
	Overweight					
	Active substance abuse					
	Non-Adherence to Treatment Regimen					
	ETOH abuse					
	Smoking tobacco and/or chewing tobacco					
		No			**Yes**	
	Practices unsafe sex					

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment			0	1	2	3	Comment
	Diet and Nutrition						
	Weight appropriate for height						
	< 90% of Ideal Body Weight						
	> 10% Unintentional Weight Loss						
	CD4 & Viral Load						
	CD4 > 500						
	CD4 499 - 350						
	CD4 349 - 51						
	CD4 < 50						
	Viral Load						
	Undetectable						
	51 - 10,000						
	10,001 - 19,999						
	> 20,000						
	Absence of Antiretroviral Therapy (1 answer only)						
	CD4 < 350 regardless of VL						
	CD4 350 - 500 & VL >5,000						
	CD4 > 500 & VL >30,000						
	Past and Present Medical History						
	Hospitalizations, OI's and Co-Morbid conditions--1 pt each						
	Cancer--in the past						
	Pain	0-2					
		3-5					
		6-8					
		9-10					
	Current Medication Regimen						
	Currently not prescribed any medications						
	Currently taking antiretrovirals only						
	Taking both antiretrovirals and other meds						
	Taking other medication (Non ARV)						

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
Activities of Daily Living						
	(Select the most appropriate answer)	Independent	Minimal Assist	Max Assist	Dependent	
	Personal Hygiene					
	bathing					
	oral hygiene					
	toileting					
	grooming					
	dressing					
	Nutritional Status					
	grocery shopping					
	cooking					
	feed self					
	Activity					
	ambulate (walking)					
	transfers (if using devices)					
	driving					
	use public transportation					
	clean home					
	child care					
	pay bills					
	can use phone					
	fill out forms					
	medication administration					
	medical testing--BGM or BP					
	medical treatment--dressings					
	Sense impairment	No	Yes			
	Sight					
	Hearing					
	Reading					
	Speech					

Scoring Methodology	1 - Low	2- Medium	3 - High
	0-24	25-35	>36

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

POSITIVE HEALTHCARE

Name: **Acuity Determination Tool**		
Approved By:	Date: September 2002	No:
Director PHC Florida _____ Chief of Managed Care	Review Date: May 14, 2004 Revised Date: May 14, 2004	

POLICY:

The Acuity Determination Tool (ADT) will be used in conjunction with the AHF/Positive Healthcare Initial Assessment/Reassessment Tool to assist the RN Care Manager (RNCM) in determining a client's level of need.

PROCEDURE:

Upon completion of the Initial/Reassessment, the RNCM will:

1. Determine a preliminary acuity based on their clinical judgment.
2. Complete a preliminary acuity form and give it to the PAC Case Manager immediately following the assessment.
3. Enter the assessment within 30 days and provide a computer generated final acuity level which based on the following scores:

    0-24 = Severity Level 1
    25-35 = Severity Level 2
    36 or greater = Severity 3

The RNCM has the authority to override the severity level assigned according to scale; the reason must be justified in a progress note and written on the computer generated acuity form.

Project AIDS Care Preliminary Acuity Determination

The preliminary acuity level assigned to this patient is a ____. This is based on a face-to-face medical needs assessment only. The final acuity level is pending a medical record review at the provider's office and a Plan of Care meeting with the primary care provider and other members of the healthcare team, including the case manager.

Once this is complete, you will receive final acuity level determination for your records.

Thank you,

AHF/Positive Healthcare
RN Care Manager

Patient name: _____

Medicaid ID#: _____

Date assessed: _____

POSITIVE HEALTHCARE

Acuity Determination Tool

Patient :

ID: Enrolled Date: 9/1/2003

Assessment Date: 12/8/2003

Care Manager:

1. Social Demographics: Total		**3**
Marital Status:	Domestic Partner	0
Multiple dependents	No	0
Children:	No	0
Housing:	Alone	2
Support System	Friends	
Income:	$10K-$20K	1
Education:	Some College	0
Written Materials:	English	0
Primary Language:	English	0
Mailings:	Education/PHC/Thrive	0
Unsafe Sex:	Condoms Always	0
2. Living Environment: Total		**4**
Dwelling Type:	Apartment	0
Phone:	Yes	0
Water:	Yes	0
Gas:	No	2
Electricity:	Yes	0
Stove:	Yes	0
Refrigerator:	Yes	0
Transportation:	Public	2
HIV Status Known:	N/A	0
3. Employment		
Employment:	No	3
Disabled:	Yes	1
4. Assistance benefits		
Benefits:	1 - 2	2
5. Body Measurements		
Weight:	Appropriate for Height	0
6. Active Substance Abuse		
Currently Using:	Yes	3
7. Tobacco		
Currently Using:	No	0
8. Mental Health Risk		
Challenges:	Yes, In Care	1
Mental Health Care:		
9. Pain		
Pain Scale:	3-5	1

10. Daily Living Activities: Total		**1**
Personal Hygiene:	Total	0
Bathing:	Independent	0
Oral Hygiene:	Independent	0
Toileting:	Independent	0
Grooming:	Independent	0
Dressing:	Independent	0
Nutritional Status:	Total	1
Grocery shopping	Independent	0
Cooking:	Minimal Assistance	1
Feed self:	Independent	0
Activity:	Total	0
Ambulate:	Independent	0
Transfers:	Independent	0
Driving:	Independent	0
Public Transport.	Independent	0
Clean Home:	Independent	0
Child Care:	None	0
Pay Bills:	Independent	0
Use Phone:	Independent	0
Fill Out Forms:	Independent	0
Medical Admin.:	Independent	0
Medical Testing:	Independent	0
Medical Treatm.:	Independent	0
Sense Impairment:	Total	0
Sight:	Yes	0
Hearing:	Yes	0
Reading:	Yes	0
Speech:	Yes	0
11. Current Medication Regimen		
Medications:	ARV, Non-ARV, Prophylactic	3
12. Past and Present Medical History		
Diagnosis:	Current Co-Morbid conditions	3
Cancer:	No Current Records	0
13. Lab Results		
CD4 Abs.:	Last Result: 345.00	2
Viral Load:	Last Result: 1,050.00	1
14. Absence of ARV Therapy		
ARV Meds:	Are Currently Present	0

Total Result: 28

Severity Level is equal: 2