Providence HEALTH CARE

IMMUNODEFICIENCY CLINIC
FIRST CONTACT ASSESSMENT

Date: _____

PATIENT CONTACT/DEMOGRAPHIC DETAILS

MSP/Health Insurance: ☐ No ☐ Yes - PHN: _____ **Other Province:** _____

Interim Federal Health: _____

Contact Details: _____

☐ OK to leave phone messages ☐ OK to send letters

Emergency Contact: _____ ☐ OK to phone

Contact is aware of patient's HIV status: ☐ No ☐ Yes

INTAKE ASSESSMENT

Date of Diagnosis: _____ Referral Source: _____

Reason for referral: ☐ New diagnosis ☐ Need primary care

☐ Transfer - Previous provider: _____

HIV risk factor: ☐ MSM ☐ Heterosexual ☐ IDU ☐ Other

Urgent medical or psychosocial issues: (Is the patient required to see MD/RN today?) _____

_____

_____

Is the patient on ARVs? ☐ No ☐ Yes If yes, specify: _____

PharmaNet consent (verbal): ☐ No ☐ Yes

COMPLEXITY SCORE:

Indicators	Unstable (score 0 points)	In transition (score 1 point)	Stable (score 2 points)	
Housing/Food/Income	☐	☐	☐	
Addictions & mental health	☐	☐	☐	
Engagement & adherence	☐	☐	☐	**Total Score:** _____
Medical complexity	☐	☐	☐	

Progress Notes: _____

_____

_____

_____

_____

Follow-up Appointments	Date	Time
Nurse: _____	_____	_____

Signature: _____ **Printed name**: _____

Providence HEALTH CARE

IMMUNODEFICIENCY CLINIC
FIRST CONTACT ASSESSMENT

Date: _____

MEDICAL HISTORY & SCREENING

Allergies/ Intolerances/ Drug Reactions:
Complete Caution Sheet

Ethnic origins:
☐ Caucasian ☐ Asian
☐ Hispanic ☐ Black
☐ South Asian ☐ Aboriginal
☐ Other: _____

Substance Use History:
Smoking: ☐ Active ☐ Former ☐ Never
Alcohol: ☐ Active ☐ Former ☐ Never
IDU: ☐ Active ☐ Former ☐ Never
Specify: _____
_____
Marijuana: ☐ Active ☐ Former ☐ Never
Other: _____
☐ Active ☐ Former ☐ Never

Other Medical/Significant Co-Morbidities:
☐ Cardiovascular disease ☐ Hepatitis B
☐ Hypertension ☐ Hepatitis C
☐ Dyslipidemia ☐ Psychiatric diagnosis
☐ Diabetes ☐ Cognitive impairment
☐ Renal disease ☐ Depression
☐ Osteoporosis ☐ Neoplasm
Site: _____

HIV Specific Blood Tests
HIV Ab: ☐ Yes ☐ No
CD4: _____
Date: _____
pVL: _____
Date: _____
HLA-B5701: ☐ Yes ☐ No
Genotype: ☐ Yes ☐ No

Tests / Date:
BP: _____
Weight: _____ kg
Height: _____ cm
Bloodwork done: ☐ Yes ☐ No
Other: _____
_____

Baseline Screening:
HBsAg: Date: _____ Result: _____
HBsAb: Date: _____ Result: _____
HBcAb: Date: _____ Result: _____
AntiHAV: Date: _____ Result: _____
HCVAb: Date: _____ Result: _____
Toxo: Date: _____ Result: _____
RPR: Date: _____ Result: _____
HLA-B5701: Date: _____ Result: _____
PAP Smear: Date: _____ Result: _____
Chest X-Ray: Date: _____ Result: _____
PPD: Date: _____ Result: _____

☐ Consent forms signed ☐ Self-care discussed ☐ Clinic orientation provided ☐ Peer navigator introduction

Follow-up Appointments	Date	Time
Doctor: _____		
Nurse: _____		

Progress Notes: _____

Signature: _____ **Printed name:** _____