WHITMAN-WALKER CLINIC

Austin Center for Health and Living Referral form

(fax # (202) 797-3531)

Client Information		
Name		Whitman-Walker Clinic ID Number
Street Address		
City, State, Zip code		DC Medicaid #
Telephone Number	Social Security Number	Date of Birth
Age	Sex	Ethnicity
Height	Weight	Recommended Participation ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 days per week
Case Manager Name	Telephone Number	Referring Agency
Reason for Referral		
Present Living Situation		

Emergency Contact Information		
Name	Daytime Phone	Evening Phone
Street Address		
City, State, Zip code		

Is emergency contact aware of HIV status? ☐ Yes ☐ No

May we call you at home? ☐ Yes ☐ No

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Medical Information

Patient Demographics				Patient History	
Last Name, First Name				**Medical History**	**HIV/AIDS History Opportunistic Infections**
Age	DOB	Sex		Food or Medication Allergies	✍✍ PCP ✍✍ Toxoplasmosis ✍✍ Cryptococcal meningitis ✍✍ Candidiasis ✍✍ Wasting Syndrome ✍✍ Dementia ✍✍ Peripheral Neuropathy ✍✍ MAC ✍✍ ___________________ ✍✍ ___________________ ✍✍ ___________________ ✍✍ ___________________ ✍✍ ___________________ ✍✍ ___________________
Date of : Last TB Screening (PPD): __________ Result: neg ☐ pos☐ Date of last CXR:________ Result: neg☐ pos☐ ☐copy of report attached *(*PPD must be within 90 days of starting date at ACHL; if T-cell count is below 300, Chest X-ray must be taken.)*	Date 1st Diagnosed with HIV: AIDS Diagnosis: Transmission Risk: CDC Classification: Date:			✍✍ HTN ✍✍ DM ✍✍ Asthma/COPD ✍✍ Tuberculosis ✍✍ Smoking ✍✍ Cardiac Disease ✍✍ Hepatic Disease ✍✍ ETOH use/abuse ✍✍ Drug use/abuse ✍✍ Mental health problem ✍✍ ___________________ ✍✍ ___________________	

Current Medication Regimen				
Anti-Retrovirals			**Prophylactic Agents**	**Other**
NNRTI ✍✍ Nevirapine (Viramune) ✍✍ Efavirenz (Sustiva) ✍✍ Delavrdine (Rescriptor)	NRT ✍✍ Lamivudine/zidovudine (Combivir) ✍✍ Lamivudine – 3TC (Epivir) ✍✍ Stavudine – d4T (Zerit) ✍✍ Abacavir (Ziagen) ✍✍ Zalcitabine – ddC (Hivid) ✍✍ Didanosine – ddI (Videx) ✍✍ Videx EC ✍✍ Zidovudine (Retrovir) ✍✍ AZT/3TC/Abacavir (Trizivir) ✍✍ Tenofovir (Viread)	PI ✍✍ Indinavir (Crixivan) ✍✍ Saquinivir (Fortovase) ✍✍ Helfinavir (Viracept) ✍✍ Ritonavir (Norvir) ✍✍ Amprenavir (Agenerase) ✍✍ Loprinavir/Ritonavir (Kaletra)	✍✍ Clarithromycin (Biaxin) ✍✍ Dapsone ✍✍ TMP/DSX (Bactrim) ✍✍ Azithromycin (Zithromax) ✍✍ Fluconazole (Diflucan)	✍✍ ✍✍ ✍✍ ✍✍ ✍✍

Most Recent
CD4/CD8: __________ Date: __________

Most Recent
Viral Load: __________ Date: __________

Date of
Last Pneumovax: __________

Date of
Last Well Woman Exam (PAP SMEAR): __________

Date of
Last RPR: __________ Results: __________

Hepatitis B
Antigen Status: ________ Antibody Status: ________

Hepatitis C
Antibody Status: ________

Provider Information	
Name	**Telephone Number**
Street Address	
City, State, Zipcode	
Physician's Signature	**Date**