The **AYA Circle of Care**
HIV-ICM Program

REFERRAL FORM
(External)

Section A: CLIENT DEMOGRAPHICS

First Name _____ Surname _____
Preferred Name _____ Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
DOB _____ Age _____ Sex ☐ Male ☐ Female ☐ Other _____

Gender Identity: ☐ Male ☐ Female ☐ Trans – Female to Male ☐ Trans – Male to Female ☐ Intersex ☐ Two Spirited ☐ Don't Know ☐ Prefer not to answer

Sexual Orientation: ☐ Bi sexual ☐ Queer ☐ Heterosexual ☐ Prefer not to answer ☐ Lesbian ☐ Don't Know

Ethnicity - must identify with one of following to meet program criteria ☐ African ☐ Caribbean ☐ Black

Language(s) Spoken _____ Preferred language to communicate _____
Client Address Address _____ Interpreter required ☐ Yes ☐ No
City _____ Province _____ Postal Code _____
Phone Number ☐ Cell ☐ Work ☐ Other: Number Verified ☐ Yes ☐ No
Health Insurance # _____
Drug Coverage ☐ Private ☐ Trillium ☐ NHIB ☐ Seniors ☐ Interim Federal ☐ ODSP/ODB ☐ OHIP+(under 25) ☐ No Coverage ☐ Other

Section B: HIV MEDICAL HISTORY

Referral Date _____ Referred by _____ Designation ☐ MD ☐ NP
New Diagnosis ☐ Yes ☐ No ***If YES, Complete Section C** If Yes, When Dx _____
If No, When Dx _____
Is client aware of Dx ☐ Yes ☐ No Is client aware of referral? ☐ Yes ☐ No
Most Recent Bloodwork HIV- RNA (Viral Load): _____ Date: _____ Or ☐ Not Available
CD4: _____ Date: _____ Or ☐ Not Available

Has any additional bloodwork such as HLA*B5701, and genotyping been collected? ☐ Yes ☐ No
If yes, please attach copy of most recent bloodwork (including):

☐ HIV-RNA ☐ CD4 cell count ☐ Tropism testing ☐ CD8 count ☐ CBC & Diff
☐ Genotypic Resistance ☐ LFT ☐ Lipid Profile ☐ FBS ☐ A1C
☐ Hepatitis Serology ☐ HLA*B5701 ☐ Renal Profile ☐ UA with Urine protein/creatine

Has the client started ART/ARV? ☐ Yes ☐ No If NO ART initiation, readiness to start ☐ Yes ☐ No
If YES, when _____ Specify medication(s) _____
If YES, know, reason for any Interruption in Tx _____

Has the client been on any other ART other than specified ☐ Yes ☐ No If Yes, When _____
If YES, specify medication _____ Duration (wks) _____
If YES, known reason for discontinuing _____

Has client been referred to HIV Specialist ☐ Yes ☐ No If Yes, when _____
Name of Md _____

Has client ever use PrEP? ☐ Yes ☐ No ☐ Unknown If YES, last known use _____
Has client ever use PEP? ☐ Yes ☐ No ☐ Unknown If YES, last known use

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Section C: Completely **ONLY** if New Dx (<6 months Dx)
Does patient have any signs & symptoms of Acute HIV Infection? ☐ Yes ☐ No If YES, onset date _____ Signs & Symptoms ☐ Fever ☐ Malaise ☐ Myalgia ☐ Rash ☐ Headache ☐ Pharyngitis

Section D: Past Medical History
Please attach CPP (Clinical Patient Profile) to referral ☐ Done OR ☐ Not Available OR list known co-morbidities _____ _____ _____
Please attach current medication list (CPP) ☐ Done ☐ n/a or not available Does client have a Primary Care Practitioner? ☐ Yes ☐ No If yes, name of MRP _____ Please attach list of any known specialists, along with contact information ☐ Done ☐ n/a or not available
Most recent vital signs Blood Pressure Weight Recent Weight Loss? ☐ Yes ☐ No Heart Rate Height Attach copy of immunization records if available ☐ Done ☐ n/a or not available (including copy of cx rig contraindication to Mantoux – TST testing)
Is client pregnant ☐ Yes ☐ No If YES, GTPAL _____ GA _____ LMP _____ EDD _____ Please attach copy of Antenatal Records (including labs, DI) ☐ Done OR ☐ Not Available Has a referral been made to OB/Midwife? ☐ Yes ☐ No
Date of last STI test (if available) _____ History of STI ☐ Yes ☐ No If YES, Diagnosis _____ Date _____ Treatment
Concerns regarding potential barriers to accessing care: ☐ Employment ☐ Poverty ☐ Food Security ☐ Transportation ☐ Support (family/community) ☐ Housing ☐ Mental Health Substance Misuse ☐ Other:
Any concerns expressed by client if discussed _____

How did you come to hear about our services at TAIBU?

PLEASE FAX COMPLETED FORM TO: (416) 644-0102

TAIBU Community Health Centre
27 Tapscott Road, Unit 1
Scarborough, Ontario M1B 4Y7
Phone: (416) 644 – 3539 ext. 1003
For more information email: goodhealth@taibuchc.ca