



PHYSICIANS: A licensed, practicing physician in Los Angeles County should complete as much of this form as possible. If you do not respond to a question, we will assume that you do not have an answer to that particular question. Return to the AIDS Project Los Angeles Registrar by fax at 213.201.1392 or mail to: AIDS Project Los Angeles, The David Geffen Center, 611 South Kingsley Drive, Los Angeles, CA 90005.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
DATE

DIAGNOSIS: (Choose only one)
[ ] HIV+ Asymptomatic (No Symptoms) [ ] HIV+ Symptomatic
[ ] AIDS Asymptomatic (No Symptoms) [ ] AIDS Symptomatic

What was the date of this diagnosis? \_\_\_\_\_ Year of first positive test for HIV: \_\_\_\_\_
DATE

Symptoms that substantiate this diagnosis:

[ ] Diarrhea [ ] Fevers [ ] Fatigue [ ] Other \_\_\_\_\_

Opportunistic infections that substantiate this diagnosis:

[ ] CD4 < 200/14% \_\_\_\_\_ DATE [ ] KS \_\_\_\_\_ DATE
[ ] PCP \_\_\_\_\_ DATE [ ] Other \_\_\_\_\_ DATE

Current symptoms related to HIV disease or treatment include: \_\_\_\_\_

LAB DATA: CD4 cell count \_\_\_\_\_ ; CD4 percentage \_\_\_\_\_ % as of \_\_\_\_\_ DATE
HIV viral load \_\_\_\_\_ as of \_\_\_\_\_ DATE
Neutrophil count \_\_\_\_\_ cells/mm3 as of \_\_\_\_\_ DATE

OTHER ILLNESSES: Is there any other illness we need to be aware of? [ ] Yes [ ] No If yes, please describe:

KARNOFSKY SCALE ASSESSMENT: (Please check the appropriate numerical value)

[ ] 100 = Stage I [ ] 80 = Stage I [ ] 60 = Stage II [ ] 40 = Stage III [ ] 20 = Stage III
[ ] 90 = Stage I [ ] 70 = Stage II [ ] 50 = Stage II [ ] 30 = Stage III [ ] 10 = Stage IV

SKILLED NURSING CARE: Does this patient meet the nursing facility level of care? [ ] Yes [ ] No

DENTAL: Is this patient medically able to receive routine dental care and/or oral procedures? [ ] Yes [ ] No

TUBERCULOSIS: Has this patient been screened for TB? [ ] Yes [ ] No

TB skin test date \_\_\_\_\_ [ ] Positive [ ] Negative
TB chest X-ray date \_\_\_\_\_ [ ] Positive [ ] Negative

This patient is currently . . . [ ] Receiving preventative TB treatment [ ] Not receiving treatment
[ ] Receiving treatment for active TB [ ] Non-compliant with recommended treatment

I am the physician responsible for the above patient's HIV care. I certify that the above information is correct and based on a review of the patient's HIV treatment needs.

Signature of Physician \_\_\_\_\_

Date Completed \_\_\_\_\_

Physician's Name \_\_\_\_\_

CA License # \_\_\_\_\_

Address \_\_\_\_\_

( ) \_\_\_\_\_

Phone \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_