UPDATED MARCH 2015

INSURANCE SERVICES PROGRAM
PHYSICIANS STATEMENT OF DIAGNOSIS

Patient Name: ____________________________________ **SS#:** ____

STEP 1: **Check one of the following:**

	This patient tested positive for HIV on: _____________________.
	This patient has NOT tested positive for HIV.

STEP 2: **Please circle one of the following CDC Staging Classifications using the chart below AND the symptom charts in STEP 4 as guides:**

A1 A2 A3 B1 B2 B3 C1 C2 C3

		Clinical Categories		
CD4 + T-cell Categories	**CD4 + Percentage**	**(A) Asymptomatic Acute (primary) HIV or PGL**	**(B) Symptomatic Not (A) or (C) Conditions**	**(C) AIDS-Indicator Conditions**
(1) > 500/uL	>29%	**A1**	**B1**	**C1**
(2) 200-499/uL	14-28%	**A2**	**B2**	**C2**
(3) <200/uL	<14%	**A3***	**B3**	**C3**
AIDS Indicator T-cell count				

*A3 is an AIDS indicator, regardless of the presence of symptoms; therefore, the client is eligible for the Insurance Services Program

STEP 3: **Most Recent Laboratory Values**

CD4 (Absolute/Percent) ______________/_____________% as of _____________ *(Date)*
Viral Load ____________________ copies per ML as of ___________ *(Date)*

STEP 4: **Please check the following Symptoms/Conditions the patient has had at any time since testing HIV positive.**

	A. Conditions Include:
	PGL Persistent Generalized Lymphadenopathy
	Acute (primary) HIV infection with accompanying illness or history of acute HIV infection
	Asymptomatic HIV infection

B. Category B consists of symptomatic conditions in an HIV infected adolescent or adult that are not included among conditions listed in clinical Category C and that meet at least one of the following criteria: (a) the conditions are attributed to HIV infection or are indicative of a defect in cell mediated immunity; or (b) the conditions are considered by physicians to have a clinical course or to require management that is complicated by HIV infection. Examples of conditions in clinical Category B include, but are not limited to:

	Bacillary angiomatosis		Herpes zoster (shingles), involving at least two distinct episodes or more than one dermatoma
	Candidiasis, oropharyngeal (thrush)		Idiopathic thrombocytopenic purpura
	Candidiasis, vulvovaginal, frequent, or poorly		Listeriosis

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	responsive to therapy		
	Cervical dysplasia (moderate or severe)/cervical carcinoma in situ		Pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess
	Constitutional symptoms, such as fever (38.5C) or diarrhea lasting > 1 month		Peripheral neuropathy
	Hairy leukoplakia, oral		Other (please list):
C. Conditions Include:			
	Candidiasis of bronchi, trachea, or lungs		Lymphoma, Burkitt's (or equivalent term)
	Candidiasis, esophageal		Lymphoma, immunoblastic (or equivalent term)
	Cervical cancer, invasive		Lymphoma, primary of brain
	Coccidioidomycosis, disseminated or extrapulmonary		Mycobacterium avium complex or M. Kansasii, disseminated or extrapulmonary
	Cryptosporidiosis, chronic intestinal (>1 month duration)		Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
	Cytomegalovirus disease (other than liver, spleen, or nodes)		Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
	Cytomegalovirus retinitis (with loss of vision)		Pneumocystis carinii pneumonia
	Encephalopathy, HIV related		Pneumonia, recurrent
	Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumenitis, or esophagitis		Progressive multifocal leukoencephalopathy
	Histoplasmosis, disseminated or extrapulmonary		Salmonella septicemia, recurrent
	Isosporiasis, chronic intestinal (> 1 month duration)		Toxiplasmosis of brain
	Kaposi's sarcoma		Wasting Syndrome due to HIV
			Other (please list):

Patient's Release: *I hereby authorize you to release this completed Physician's Statement of Diagnosis to Suncoast Health Council, Inc. which will use it to determine my eligibility for program services through the Insurance Services Program.*

Client Signature: ______________________________

Physician Signature: ______________________________

Physician Name: ______________________________

Physician License Number: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Case Manager Name: ______________________________

(Please print clearly)

Case Manager Phone: ______________________________

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