CONTRA COSTA COUNTY AIDS PROGRAM
Minimum Required Dataset Form for ARIES

(Check One) **New Intake** ☐ **Update** ☐

Client Intake And Needs Assessment

Last Name:

First Name:

Middle Initial:

Mother's Maiden Name:

Date of Birth:

Gender:
- ☐ Male
- ☐ Female
- ☐ Transgender MTF
- ☐ Transgender FTM
- ☐ Other
- ☐ Unknown
- ☐ Client Refused to Report

Program (Check all that apply):
- ☐ Medi-Cal Waiver Program (MCWP)
- ☐ Part A
- ☐ Part B (HCP)
- ☐ Part C
- ☐ ADAP
- ☐ Other _____

Share/Non-Share Status

☐ Client Agrees to Share Data ☐ Client Does Not Agree to Share Data

Date of Intake _____ Staff Person: _____
*** Attach a copy of ARIES Consent Form (Share/Non Share).**

Agency: _____

NOTE: When an AKA is known, or multiple iterations of one name are used, please photocopy any document used to determine name. Please complete AKA on page 3.

Gray shaded items are core elements and must be completed before entering data into ARIES. Service providers are responsible for completing the remainder of the intake.

Demographics – Contact Information

ADDRESS COMPLETE ALL ITEMS IN THIS BOX	*PHONE AND EMAIL COMPLETE ALL ITEMS BELOW*

Residence/Current Address: Since: __/___/____

Street 1: _____

Street 2: _____

City: _____

State: _____ Zip Code: _____

County: _____

Area of County (Circle One): East Central West

Mailing Address: □ Same as residence

Street 1: _____

Street 2: _____

City: _____

State: _____

Zip Code: _____

County: _____

Previous Address: □ Same as residence

Since: ____/____/____(Date)

Street 1: _____

Street 2: _____

City: _____

State: _____

Zip Code: _____

May we contact you by mail?
□ Yes □ No
Should mail be confidential?
□ Yes □ No

EMERGENCY

Name:_____

Street 1:_____

Street 2:_____

City: _____

State:_____ Zip Code:_____

Telephone 1: (_____)_____
Telephone 2: (_____)_____
Confidential: □ Yes □ No
Messages OK: □ Yes □ No

Telephone 1: (_____)_____
Phone Type:
□ Work □ Home □ Mobile
□ Fax □ Message □ TTY
Allow Calls?
□ Yes □ No
Confidential?
□ Yes □ No
Messages OK?
□ Yes □ No

Telephone 2: (_____)_____
Phone Type:
□ Work □ Home □ Mobile
□ Fax □ Message □ TTY
Allow Calls?
□ Yes □ No
Confidential?
□ Yes □ No
Messages OK?
□ Yes □ No

Email1:
_____

Allow Contact by E-Mail?
□ Yes □ No
Confidential?
□ Yes □ No
Messages OK?
□ Yes □ No

Demographics – Demo Detail

AKA: _____ SSN: _____

Hispanic:
□ Yes □ No □ Unknown
If yes, national origin/ethnicity: _____

Race 1:	Race 2:
□ White □ Black □ Asian □ American Indian/Native Alaskan □ Pacific Islander □ Other □ Unknown/Unreported	□ White □ Black □ Asian □ American Indian/Native Alaskan □ Pacific Islander □ Other □ Unknown/Unreported
Marital Status: □ Single □ Married □ Domestic Partnership □ Cohabitation □ Separated □ Divorced □ Widowed	Sexual Orientation: □ Heterosexual □ Homosexual □ Lesbian □ Bisexual □ Declines to State □ Unsure/Questioning □ Asexual □ Pediatric/Not Applicable □ Unknown
Veteran: □ Yes □ No □ Unknown	
Primary Language: □ English □ Spanish □ Tagalog □ Mandarin □ Cantonese □ Vietnamese □ Other	Education Level: □ No high school □ Some high school □ High school diploma/GED □ Trade/Technical □ Some college education □ College degree □ Some graduate education □ Graduate degree □ Unknown
Secondary Language: □ English □ Spanish □ Tagalog □ Mandarin □ Cantonese □ Vietnamese □ Other	Special Needs: □ Hearing □ Vision □ Wheelchair □ Mobility □ Speech □ Translation □ More than one □ Unknown
Place of Death: □ Home □ Hospital □ Nursing Facility	Date of Death: ____/____/____ □ Residence Hospice/RCF-CI □ Other: _____
Notes: _____	

Demographics – Living Situation

Current living situation since: ____/____/____

Current Living Situation (Choose One):

- □ Homeless from the Streets
- □ Homeless from Emergency Shelter
- □ Transitional Housing
- □ Psychiatric Facility
- □ Substance Abuse Treatment Facility
- □ Hospital or Other Medical Facility
- □ Jail/Prison
- □ Living with Relatives/Friends
- □ Rental Housing
- □ Participant Owned Housing
- □ Board, Care or Assisted Living
- □ Rented Room
- □ Refused to Answer
- □ Other
- □ Unknown

Housing Assistance:

- □ HOPWA
- □ HUD Shelter+Care
- □ Section 8/Housing Choice Vouchers
- □ HUD (If checked, HUD Application Date: ____/____/_____)
- □ Tenant-Based Project
- □ Short-Term Emergency
- □ Other

If you rent or own, do you have a signed lease, title or tax receipt? □ Yes □ No □ Unknown

If yes, list type of document: _____

HOPWA (This section is to be completed only if client receives HOPWA-funded services)

Enrollment Date: ____/____/_____

Monthly Gross Income: _____	Number of Bedrooms: _____
Median Area Income: _____	Application Type: □ Individual □ Family

Reason for Leaving Program:

- □ Voluntary departure
- □ Non-payment of rent
- □ Non-compliance with support service requirements
- □ Unknown/disappeared
- □ Criminal activity/destruction of property/violence
- □ Death
- □ In permanent housing subsidized by other sources; no subsidy
- □ Still in program
- □ Other

Client Name: _____

Demographics – Agency Specifics

Client Agrees to Share Data: □ Yes □ No

Client Status With Your Agency:

□ Active
□ Inactive
□ Disenrolled
□ Lost to Follow-Up
□ Discharged
□ Reported Deceased
□ Confirmed Deceased
□ Unknown/Unreported

Status as of Date: ____/____/____ **Agency Enrollment Date: ____/____/____**

Referral Date: ____/____/____

Referral source:
□ MD
□ Case Manager
□ Counseling and Testing and Outreach
□ RN
□ Self
□ OUTREACH
□ Other If Other: _____
□ PCRS

Reason for Status Change (If Disenrolled):
□ Referred to another program
□ Violation of Rules
□ Incarcerated
□ Relocated
□ Other If Other: _____

Agency Client ID 1 (MR#)_____ Agency Client ID 2: (Prog)_____

Agency User Field 1: _____ Agency User Field 2: _____

Client Alert: _____

Eligibility – Eligibility Documents - Verification of Documentation in Client File

□ **Agency Consent Date: _____**

Type: **HIV Letter of Diagnosis/Proof of Diagnosis**

□ Obtained by this agency

□ Obtained by another agency
Location: _____

Document Dated: ___/___/___

Obtained: ___/___/___

*** Source: _____**

Type: **ARIES Consent Form**

□ Obtained by this agency

Document Dated: ___/___/___

Obtained: ___/___/___ Expires: ___/___/___

Source: _____

Notes: _____

Client Name: _____

Eligibility – Eligibility Documents (Con't)	
Type: **Release of Information Form** □ Pending □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____	Type: **Clients Rights/Grievance Form** □ Pending □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____
Type: **Photo ID (source of spelling of name)** □ Pending □ In File □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____	Type: HIPAA □ Pending □ In File □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____
Type: **Proof of Residency** (rental receipt, utility bill or other bill indicating residency in Contra Costa) □ Pending □ In File □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____	Type: **Income** □ Pending □ In File □ Obtained by this agency Document Dated: ___/___/___ Obtained: ___/___/___ Expires: ___/___/___ Source: _____ Notes: _____

ADAP

Date of Enrollment: _____	Date Recertification Completed: _____
Length of Grace Period: _____	Inactive/Closing Date: _____
Missing Documentation: _____	_____
_____	_____

Eligibility - Financial

Monthly Client Income Data

Employed:
□ Full-Time
□ Part-Time
□ Not Employed
□ Other – Student, Volunteer, Etc.
□ Unknown

Public Assistance:
□ Yes
□ No
□ Unknown

Employment Wages: $ _____

Supp Security Income / SSI: $ _____

Soc Security Disability Ins / SSDI: $ _____

Social Security Retirement: $ _____

Gen Assist / Gen Relief / GA / GR: $ _____

Unemployment / UI: $ _____

State Disability Ins / SDI: $ _____

Long-term Disability / LTD: $ _____

Worker's Compensation: $_____

TANF Cal WORKS: $ _____

Veterans Benefits / VA: $ _____

Alimony / Child Support: $ _____

Retirement: $ _____

Investment: $ _____

Gift: $ _____

Other 1: _____ $_____

Other 2: _____ $_____

Other 3: _____ $_____

□ No Source of Income

Food Stamps: $ _____

(Total income of all categories will be calculated/displayed in ARIES)
Copy of unemployment benefit stub (can be obtained at Employment Development Department, 800-300-5616)

Monthly Household Income Data

Monthly Household Income: $ _____

Number of People in Household: _____

Number of Children in Household: _____

Number of HIV+ People in Household: _____

(Percent of federal poverty level will be calculated/displayed in ARIES)

Monthly Family Income

Family Income: $ _____

Number of People in Family: _____

(Percent of federal poverty level will be calculated/displayed in ARIES)

Assets

Do you own a home? □ Yes □ No

Do you own a car? □ Yes □ No

Do you have other assets? □ Yes □ No $ _____

Copy of unemployment benefit stub can be obtained at Employment Development Department 800-300-5616

Client Name: _____

Eligibility - Insurance

Primary Insurance: □Yes □ No **Primary HIV Insurance** □Yes □ No

Source:	Type:
□ Veteran □ Public 1 (LIHP) □ Medicare □ Public 1 (BHC) □ Public 2 (CCHP Public) □ Other Public Insurance □ Private 1 (CCHP Private) □ Other □ Private 2 □ Unknown □ Private 3 □ No Insurance □ Medi-Cal/Medicaid □ Pending Carrier: □ Blue Cross □ Contra Costa Health Plan (CCHP) □ Kaiser □ Aetna □ Other: _____ Policy Number: _____ Start Date: _____ End Date: _____ Monthly Premiums: _____	□ LIHP □ County-Sponsored □ Full Scope □ COBRA □ Shared Cost □ COBRA-Individual □ Managed □ COBRA-Family □ Restricted □ OBRA □ Baby □ OBRA-Individual □ DentiCAL □ Cal-COBRA □ Medi-Care A □ HIPIC □ Medi-Care A & B □ Conversion (RX) □ Medi-Care D □ Private Self-Pay □ Veterans □ Individual Self-Pay □ Family Self-Pay □ CMSP □ North Star □ CHAMPUS □ CHIPPS □ Other □ OBRA-Family □ Unknown □ Family Medical Leave Act □ No Insurance □ CA Children's Services **Notes:** Medi-Cal eligibility recertification due _____

Secondary Insurance: □Yes □ No **Primary HIV Insurance** □Yes □ No
(If ADAP only check No and mark ADAP below)

Source:	Type:
□ ADAP □ Public 1 (LIHP) □ Veteran □ Public 1 (BHC) □ Medicare □ Public 2 (CCHP Public) □ Other Public Insurance □ Private 1 (CCHP Private) □ Other □ Private 2 □ Unknown □ Private 3 □ No Insurance □ Medi-Cal/Medicaid Pending □ Yes □ No Carrier: □ Blue Cross □ Contra Costa Health Plan (CCHP) □ Kaiser □ Aetna □ Other: _____ Policy Number: _____ Start Date: _____ End Date: _____ Monthly Premiums: _____	□ LIHP □ County-Sponsored □ Full Scope □ COBRA □ Shared Cost □ COBRA-Individual □ Managed □ COBRA-Family □ Restricted □ OBRA □ Baby □ OBRA-Individual □ DentiCAL □ Cal-COBRA □ Medi-Care A □ HIPIC □ Medi-Care A & B □ Conversion (RX) □ Medi-Care D □ Private Self-Pay □ Veterans □ Individual Self-Pay □ Family Self-Pay □ CMSP □ North Star □ CHAMPUS □ CHIPPS □ Other □ OBRA-Family □ Unknown □ Family Medical Leave Act □ No Insurance □ CA Children's Services **Notes:**

Medical – Basic Medical

Primary Medical Care (select one):

□ Alternative/Complementary Care
□ County Clinics and Hospitals (e.g. **CCRMC, Richmond HC, Pittsburg HC, etc.)**
□ Community-Based Clinics, Public **(Brookside, La Clinica, etc)**
□ Community-Based Clinics, Private
□ HMO Hospital/Clinics (e.g., Kaiser)
□ VA Hospital, CHAMPUS
□ Other Federally Qualified Health Center/Hospital
□ Private MD
□ Emergency Room
□ No Primary Care
□ Other
□ Unknown

Name of Provider: _____

Phone #: _____ Last Visit: ___/___/___

Primary HIV Care (select one):

□ Alternative/Complementary Care
□ County Hospital and DPH Clinics
□ Community-Based Clinics, Public
□ Community-Based Clinics, Private
□ HMO Hospital/Clinics (e.g., Kaiser)
□ VA Hospital, CHAMPUS
□ Federally Qualified Health Center/Hospital
□ Private MD
□ Emergency Room
□ No Primary Care
□ Other (HOW Van)
□ Unknown

Name of Provider: _____

Phone #: _____ Last Visit: ___/___/___

CDC Disease Stage:

□ HIV Negative
□ HIV Positive, Disease Stage Unknown
□ HIV Positive, Asymptomatic
□ HIV Positive, Symptomatic, Not AIDS
□ HIV Positive, Disabling
□ CDC-Defined AIDS
□ Disabling AIDS
□ Pediatric Indeterminate
□ Unreported

Source:
□ Letter of diagnosis
□ Medical Record
□ Awaiting letter of diagnosis
□ Not Applicable
□ Lab Results-Demonstrating HIV/AIDS
□ Other

Date of First HIV+: _____/_____/_____

Was first HIV Positive test received at time of AIDS diagnosis? □ Yes □ No □ Unknown

HIV test Date: ____/____/_____

Result:
□ Positive
□ Negative
□ Indeterminate

County: _____ State: _____

Source: _____

AIDS Diagnosis Date: ___/___/___

County: _____ State: _____

Source: _____

Pre-test Counseling:
□ Offered
□ Not Offered
□ Unknown

If yes, date: _____

Post-test Counseling:
□ Offered
□ Not Offered
□ Unknown

If yes, date: _____

Client Name: _____

Medical – Basic Medical

Partner Notification Offered:
□ Yes
□ No
□ Unknown

Date: ___/___/___

Partners to be Notified by Client: _____

Partners to be Notified by Health Dept.: _____

Date Health Dept. Notified: ___/___/___

Acuity Scale:

Karnofsky / CFA (select one for Adults >= 13 years): _____

Date: _____/_____/_____

Pediatric Scale (select one for clients <13 years): _____

Date: _____/_____/_____

Other Scale: _____

Date: _____/_____/_____

Usual Weight: _____ Current Weight: _____Date_____

Medically Unable to Work:
□ Yes
□ No
□ Unknown

Other Chronic Medical Conditions:

_____

_____

_____

Client Name: _____

Medical – Basic Medical

AIDS Defining Conditions: **Source:** _____

□ Bacterial Infections, Multiple or Recurrent (<13 only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Candidiasis, Bronchi, Trachea, or Lungs	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Candidiasis, Esophageal	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Carcinoma, Invasive Cervical (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ CD4 Count less than 200 or CD4 Percent less than 14	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Coccidioidomycosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Cryptococcosis, Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Cryptosporidiosis, Chronic Intestinal (>1 month duration)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Cytomegalovirus Disease (other than in liver, spleen, or nodes)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Cytomegalovirus Retinitis (with loss of vision)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ HIV Encephalopathy	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Herpes Simplex: Ulcers (>1 month); Bronchitis/ Pneumonitis/ Esophagitis	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Histoplasmosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Isosporiasis, Chronic Intestinal (>1 month duration)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Kaposi's Sarcoma	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Lymph Interstitial Pneumonia, Pulmonary Hyperplasia (<13 only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Lymphoma, Burkitt's (or equivalent term)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Lymphoma, Immunoblastic (or equivalent term)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Lymphoma, Primary in Brain	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ MAC or M. Kansasii, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ M. Tuberculosis, Pulmonary (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ M. Tuberculosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Mycobacterium of Other/Unknown Species, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Pneumocystis Carinii Pneumonia	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Pneumonia, Recurrent in 12-Month Period (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Progressive Multifocal Leukoencephalopathy	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Salmonella Septicemia, Recurrent (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Toxoplasmosis of Brain	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Wasting Syndrome due to HIV	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
□ Other Diagnosis:_____	Diagnosis Date: ___/___/___ Tx Date: ___/___/___

Medical – Medical History

CD4 Date: ___/___/___ T Cell Count: _____ Source: _____	Viral Load Date: ___/___/___ Value: _____ Source: _____	Test Type: □ Roche PCR Standard □ Roche PCR Ultrasensative □ Bayer bDNA □ BioMerieux NucliSens

STI/Hepatitis: **Source:** _____

Type	Test Date	Diagnosis	Lab Value	TX Ind?	TX Start Date	TX End Date	Outcome
□ Genital Herpes	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Gonorrhea	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Human Papillomavirus (Genital Warts)	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Syphilis	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Non-Specific Urethritis	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Hepatitis A	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Hepatitis B	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Hepatitis C	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ Chlamydia	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ HSV-1	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable
□ HSV-2	__/__/__	□ Negative Diagnosis □ Positive Diagnosis □ Presumptive □ Indeterminate □ Unknown		□ Yes □ No □ Patient Refused	__/__/__	__/__/__	□ Completed □ Not Completed □ Unknown □ Not Applicable

Medical – Medical History

Tuberculosis: (Quantiferon or PPD)

Test Medically Indicated:	Test Medically Indicated Date:	Date PPD/TST Placed or Quantiferon drawn	Date PPD/TST Read:	PPD/TST Result: (Quantiferon)	Chest X-Ray Date:	Chest X-Ray Result *(optional)*:
□ Yes □ No □ Patient Refused □ Unknown	___/____/____	___/____/____	___/____/____	□ Reactive □ Non Reactive	___/____/____	□ Positive □ Negative

TB Diagnosis and Treatment: Multi-Drug Resistance: □ Yes □ No

Diagnosis	Date of Diagnosis:	Treatment Start Date:	Treatment End Date:	Treatment Type:	Treatment Status:
□ None □ Active □ Inactive □ History of Positive PPD □ Unknown	___/____/____	___/____/____	___/____/____	□ Not Applicable □ Treatment □ Prophylaxis □ None □ Unknown	□ In Progress □ Completed □ Not Completed □ N/A □ Unknown

Immunizations:

Immunization Type:	Is not medically indicated?	Immunization Date:
□ Hepatitis A	□ Is not medically indicated	____/_____/____
□ Hepatitis B	□ Is not medically indicated	____/_____/____
□ Pneumovax	□ Is not medically indicated	____/_____/____
□ Tetanus	□ Is not medically indicated	____/_____/____
□ BCG	□ Is not medically indicated	____/_____/____
□ Flu	□ Is not medically indicated	____/_____/____
□ PCP	□ Is not medically indicated	____/_____/____
□ Other	□ Is not medically indicated	____/_____/____

ER / Hospital Visits:
Collect up to 2 ER / Hospital Visits on this form; collect as many as needed in ARIES.

Date: ____/____/____	□ ER Visit	Reason: □ HIV Related, No OI □ AIDS Related, No OI □ OI (HIV/AIDS) □ Not HIV/AIDS Related □ Other	□ Hospitalized If Hospitalized, # of days: _____
Date: ____/____/____	□ ER Visit	Reason: □ HIV Related, No OI □ AIDS Related, No OI □ OI (HIV/AIDS) □ Not HIV/AIDS Related □ Other	□ Hospitalized If Hospitalized, # of days: _____

Client Name: _____

Medical – OB/GYN & Pregnancy

OB/GYN:

Primary OB/GYN: _____ Phone Number: _____

Medically Indicated? □ Yes □ No □ Patient Refused □ Unknown □ Patient did not follow up

Pap Smear & Pelvic Exam Date:	Result:	Notes:
___/____/____		
□ Is Primary Healthcare Provider strictly an OB/GYN practitioner?		

Pregnancy: Number of Prenatal Visits in Reporting Month: _____

Date First Reported Pregnant:	Estimated Date of Conception:	Estimated Delivery Date:	HIV Status During Pregnancy:	Date Prenatal Care Began:
___/____/____	___/____/____	___/____/____	□ HIV Positive After Conception □ HIV Positive Prior to Pregnancy	___/____/____

ART Counseling Offered to Reduce HIV Transmission to Infant:	Date Received ART Counseling:	ART Was Offered to Reduce Vertical Transmission to Infant:	Date ART Was Taken:
□ Yes □ No □ Unknown	___/____/____	□ Yes □ No □ Unknown	___/____/____

Pregnancy Outcome:	Date of Pregnancy Outcome:	Newborn HIV Status:
□ Live Birth □ Therapeutic (Induced) Abortion □ Spontaneous Abortion (Miscarriage) □ Stillbirth □ Unknown	___/____/____	□ Positive □ Negative □ Indeterminate □ Unknown

Medications - ART

	Name	Phone Number	Allergies
Pharmacy 1			
Pharmacy 2			
Pharmacy 3			

ART: (Use chart to properly classify drugs)

ART Type:	Reason not on HAART	Start Date:	End Date ***(Optional)***:
□ Highly Active Anti-Retroviral Therapy (HAART) (Triple Therapy) □ Combination Anti-Retrovirals but not HAART (Dual Therapy) □ Mono Therapy □ Salvage Therapy □ None/Not Applicable □ Unknown/Unreported	□ Not Medically Indicated □ Not ready (determined by clinician) □ Client refused □ Intolerance, side-effects, toxicity □ Payment assistance unavailable □ Other_____	____/_____/____	____/_____/____

Can collect up to 4 ART Drugs on this form; collect as many as needed in ARIES.

Anti-Retroviral Drugs *(see attachment 2 for ART Drugs list)*	Prescribed By	Side Effects	Start Date	End Date	Dosage
ART 1: _____			____/_____/____	____/_____/____	
ART 2: _____			____/_____/____	____/_____/____	
ART 3: _____			____/_____/____	____/_____/____	
ART 4: _____			____/_____/____	____/_____/____	

Art Medications Adherence

In the last 3 days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor?

□ 0 □ 1 □ 2 □ 3 as of (date): _____

Adherence to HIV treatment: Percent of doses taken in the past four weeks:

□ 100%
□ >95%
□ 80% - 95%
□ 60% - 80%
□ 40% - 60%
□ 20% - 40%
□ Under 20%
□ Unknown

Date: _____

Genotypic / Phenotypic testing performed to determine resistance to HIV medications: □ Yes □ No □ Unknown	Date of Test: ____/_____/____ Notes: _____ _____

Can collect up to 4 Other medications on this form; collect as many as needed in ARIES.

Other Medications	Prescribed By	Side Effects	Start Date	End Date	Dosage
Other Medication 1: _____			____/_____/____	____/_____/____	
Other Medication 2: _____			____/_____/____	____/_____/____	
Other Medication 3: _____			____/_____/____	____/_____/____	
Other Medication 4: _____			____/_____/____	____/_____/____	

Other Medications Adherence

In the last three days, not including today, how many days did you take your other medications at the times and in the amounts prescribed by your doctor?

□ 0 □ 1 □ 2 □ 3 as of (date): _____

Risk and Assessments - Risk Factors

What behaviors did the client engage in prior to his/her first HIV positive test result? Check all that apply:

Client Risk Factors:	Sex Partner Risk Factors, Heterosexual Contact ONLY:
□ Sex with Male □ Sex with Female □ Injected nonprescription drugs □ Received clotting factor for hemophilia/coagulation disorder □ Received transfusion of blood/blood components (other than clotting factor), transplant of tissue/ organs or artificial insemination □ Worked in healthcare or clinical lab setting □ Mother HIV infected/Perinatal transmission □ Sexual abuse (pediatric only) □ Other □ Unknown	□ Intravenous/injection drug user □ Bisexual Male □ Person with AIDS or documented HIV □ Other (person with hemophilia/coagulation disorder, transfusion recipient with documented HIV infection, Transplant recipient with documented HIV infection) □ Unknown

Primary HIV Exposure: must be completed	**Secondary HIV Exposure *(Optional)*:**
□ Men Who Have Sex with Men (MSM) □ Injection Drug User (IDU) □ Men Who Have Sex with Men and Injection Drug User (MSM and IDU) □ Hemophilia/Coagulation Disorder □ Heterosexual Contact with an At-Risk or Infected Partner □ Receipt of Transfusion of Blood, Blood Components or tissue □ Mother HIV Infected/Perinatal Transmission □ Sexual Abuse (Pediatric Only) □ Other □ Undetermined □ Risk not Reported □ Unknown	□ Men Who Have Sex with Men (MSM) □ Injection Drug User (IDU) □ Men Who Have Sex with Men and Injection Drug User (MSM and IDU) □ Hemophilia/Coagulation Disorder □ Heterosexual Contact with an At-Risk or Infected Partner □ Receipt of Transfusion of Blood, Blood Components or tissue □ Mother HIV Infected/Perinatal Transmission □ Sexual Abuse (Pediatric Only) □ Other □ Undetermined □ Risk not Reported □ Unknown

Substance Abuse and Mental Illness Symptom Screener (SAMISS) *Assmt Tab* Date: _____

1. How often do you have a drink containing alcohol?
□ Never □ Monthly or less □ 2-4 x mo □ 2-3 x wk □ 4 or more x wk □ Unknown

2. How many drinks do you have on a typical day when you are drinking?
□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10+ □ Unknown

3. How often do you have 4 or more drinks on 1 occasion?
□ Never □ less than monthly □ monthly □ weekly □ daily or almost daily □ Unknown

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?
□ Never □ less than monthly □ monthly □ weekly □ daily or almost daily □ Unknown

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?
□ Never □ less than monthly □ monthly □ weekly □ daily or almost daily □ Unknown

6. In the past year, how often did you drink or use drugs more than you meant to?
□ Never □ less than monthly □ monthly □ weekly □ daily or almost daily □ Unknown

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?
□ Never □ less than monthly □ monthly □ weekly □ daily or almost daily □ Unknown

Client Name: _____

Refer to Substance Abuse □ **Yes** □ **No** **Date:** _____

8. In the past year, when no high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?
□ Yes □ No □ Unknown

9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?
□ Yes □ No □ Unknown

10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?
□ Yes □ No □ Unknown

11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work or activities that usually give you pleasure?
□ Yes □ No □ Unknown

12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?
□ Yes □ No □ Unknown

13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
□ Yes □ No □ Unknown

14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?
□ Yes □ No □ Unknown Explain: _____

15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?
□ Yes □ No □ Unknown
If yes, have you been troubled by flashbacks, nightmares or thoughts of trauma? □ Yes □ No

16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life??
□ Yes □ No □ Unknown

Refer to Mental Health Counseling □ **Yes** □ **No**

Substance Abuse Assessment Tab Sub Abuse Screen Date: ____/_____/____ Screening Tool: SAMISS Outcome: _____	**Mental Health Assessment Tab** MH Screen Date: ____/_____/____ Screening Tool: SAMISS Outcome: _____
Substance Abuse Treatment Status: □ In Treatment □ Waiting List for Treatment □ Refused Treatment □ Completed Treatment □ Pre-Treatment Process □ Dropped Out of Treatment □ No Active Treatment or Counseling □ Resumed Treatment □ Other □ Unknown □ Not Applicable Date: ____/_____/____	Mental Health Treatment Status: □ In Treatment □ Waiting List for Treatment □ Refused Treatment □ Completed Treatment □ Pre-Treatment Process □ Dropped Out of Treatment □ No Active Treatment or Counseling □ Resumed Treatment □ Other □ Unknown □ Not Applicable Date: ____/_____/____
Substance Use: □ Mild □ Moderate □ Severe □ Unknown	Notes:

Assessment Sub Tabs

Psychosocial Factors

History of Abuse

Emotional:

Childhood (<17):
- □ Yes
- □ No
- □ Unknown

Adult (>=17):
- □ Yes
- □ No
- □ Unknown

Physical:

Childhood (<17):
- □ Yes
- □ No
- □ Unknown

Adult (>=17):
- □ Yes
- □ No
- □ Unknown

Sexual:

Childhood (<17):
- □ Yes
- □ No
- □ Unknown

Adult (>=17):
- □ Yes
- □ No
- □ Unknown

Domestic Violence Observed in Childhood:
- □ Yes
- □ No
- □ Unknown

Domestic Violence Adult Perpetrator:
- □ Yes
- □ No
- □ Unknown

Barriers to Care

Date dropped out of medical care: _____

Financial Barriers
- □ Not enough money
- □ No health insurance/not enough health insurance
- □ Could not afford time off from work
- □ Other money-related reasons (specify): _____

Health Barriers
- □ Felt too sick to go
- □ Felt too depressed to go
- □ Disability prevented going
- □ Drug or alcohol use prevented going
- □ Other health related reason (specify) _____

Clinic/Facility Barriers
- □ Didn't know where to go to get care
- □ Clinic was inconvenient (location, hours, etc.)
- □ Clinic staff didn't speak client's language
- □ Clinic staff was rude/unkind
- □ Clinic waiting time was too long
- □ Unable to get appointment/apt offered too far in future
- □ Clinic rules required abstinence and/or drug testing
- □ Other clinic/facility related reason (Specify) _____

Housing/Responsibility Barriers
- □ Unable to get childcare
- □ Unable to get time off from work
- □ Needed to care for an adult family member
- □ Homeless
- □ In jail or prison
- □ Other reasons related to housing or responsibilities (specify) _____

Knowledge/beliefs barriers
- □ Didn't want to think about being HIV+
- □ Dislike of doctors/clinics
- □ Didn't believe they were infected with HIV
- □ Didn't feel sick
- □ Believed HIV medication wouldn't help
- □ Believed HIV treatment would be unpleasant or painful
- □ Too embarrassed or ashamed to go for medical care
- □ Didn't want anyone to know they were HIV-positive
- □ Other reasons related to knowledge or beliefs (specify)

_____

Psychosocial Factors: Legal

Does the client have legal issues pending in any of the following areas?

Divorce, Child Support or Custody:
- □ Yes
- □ No
- □ Unknown

Housing, Employment or Health Care Discrimination?
- □ Yes
- □ No
- □ Unknown

Client Name: _____

Immigration Status:
□ Yes
□ No
□ Unknown

Mental Health Commitment
□ Yes
□ No
□ Unknown

Social Security Disability or SSI:
□ Yes
□ No
□ Unknown

DUI:
□ Yes
□ No
□ Unknown

Other: _____

Is the client currently on parole or probation?
□ Yes
□ No
□ Unknown

How much combined time has the client spent in jail or prison (total months)? _____

Risk and Assessment Tab (Assessment Sub Tab)
Functional Status/Quality of Life: As of date: : ____/_____/____

Staff: _____

In general, would you say your health is:
□ Excellent □ Good □ Very good □ Fair □ Poor □ Unknown

Please select the option that best describes whether each of the following statements is true or false for you:

I am somewhat ill.
□ Definitely true
□ Mostly true
□ Don't know
□ Mostly false
□ Definitely false
□ Unknown

I am as healthy as anybody I know.
□ Definitely true
□ Mostly true
□ Don't know
□ Mostly false
□ Definitely false
□ Unknown

My health is excellent.
□ Definitely true
□ Mostly true
□ Don't know
□ Mostly false
□ Definitely false
□ Unknown

I have been feeling bad lately.
□ Definitely true
□ Mostly true
□ Don't know
□ Mostly false
□ Definitely false
□ Unknown