PUBLIC HEALTH DIVISION
HIV/STD/TB Program
HIV Care and Treatment Program

Oregon Health Authority

Optional form
RN File

Oregon HIV
Medical Care Coordination (MCC)
Case Conference Form

Client name: _____ Case conference date: / /

Care coordinator: _____ Medical case manager: _____

Participants (Name/position)	Agency/phone	Face to face or by phone?

Client present? ☐ Yes ☐ No

Is there a signed release for all agencies present? ☐ Yes ☐ No

Purpose of conference:

Overall assessment of client's status and current needs. Include progress in service plan areas.

Agency/individual	Agrees to	Due date

Acuity review completed? ☐ Yes ☐ No

Care coordinator signature: _____ Date: - -

Medical case manager signature: _____ Date: - -