APLA
AIDS Project Los Angeles

PHYSICIAN DIAGNOSIS FORM

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 _____ (DATE) Social Security No. _____ – _____ – _____

DIAGNOSIS: *(Choose only one)*

❑ HIV+ Asymptomatic (No Symptoms) ❑ HIV+ Symptomatic
❑ AIDS Asymptomatic (No Symptoms) ❑ AIDS Symptomatic

What was the date of this diagnosis? _____ (DATE) **Year of first positive test for HIV:** _____

Symptoms that substantiate this diagnosis:

❑ Diarrhea ❑ Fevers ❑ Fatigue ❑ Other _____

Opportunistic infections that substantiate this diagnosis:

❑ CD4 < 200/14% _____ (DATE)
❑ PCP _____ (DATE)
❑ KS _____ (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 _____