Clinical Medical Indicator Form

Today's Date: _____.

Client's Name: _____ Phone Number: _____

Date of Birth: _____

Date of client's last appointment: _____ Date of client's next appointment: _____

CD 4 Count: _____ Date: _____ Viral Load: _____ Date: _____ Copy of lab test attached: ☐ yes   ☐ no*

  * If "no," attach lab test within 60 days (grace period) to continue services and enter date attached here: _____

Hep. A: ☐ pos   ☐ neg   Hep. B: ☐ pos   ☐ neg   Hep. C: ☐ pos   ☐ neg

TB status: Date of last test: _____ Results: ☐ pos   ☐ neg   D.O.T. Therapy: ☐ yes   ☐ no

OB/GYN exam (if applicable): Date of last PAP: _____ Results: _____

Is client on a HAART regimen?   ☐ yes   ☐ no   (*Freq. Key.:   X = Number of times   E = Every)

Current Medication:

Name	Dosage	Freq.*	Name	Dosage	Freq.*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other medical conditions: _____

_____

Does client have treatment adherence issues? _____

_____

Person completing this form: _____ Certification: _____

Affiliation: _____ Phone Number: _____

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6 Month Verification: (*This section is completed within 6 months after client's lab test was attached to this form. Count 6 months from* Today's Date *above. Or, if lab test was attached during 60 day grace period, count 6 months from when it was actually attached, see " * " above.*) Verification of client's status needs to be done a minimum of every 6 months, to continue services. So, if client's lab test has not changed since the one that is attached and 6 months or less have gone by, complete this section to verify such. If more than 6 months have gone by, disregard this section and complete   a new form.

Date: _____ Person verifying: _____

Certification: _____ Affiliation: _____ Phone Number: _____