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| **Client Referral Form- Please complete all fields and remember to have client sign an ROI** | | | | |
| We provide specialized nursing care coordination and pre-conception counseling, including:  ● Coordination of medical care, treatments and appointments ● Development of a delivery plan  ● Coordination of care and screening for HIV-exposed infants ● Health education and support | | | | |
| **Name** (full legal name & preferred name if applicable)**:** | | **Referral date:** | **Referred by:**  Contact number: | |
| **Contact phone #:**  **Preferred contact:** Cell, Text, Home, Other  **Okay to leave message?** Yes / No | | **Date of birth:** | **Primary lanugage:** | |
| **Is client pregnant?**    Yes / No | **Diagnosed with HIV in current pregnancy?**  Yes / No | |
| **New patient within the last year?**  Yes / No | **Partner/father aware of patient’s HIV status?**  Yes / No | **HIV provider & clinic name and telephone number:** | | |
| **OB provider, Clinic name and telephone number:**  Provider:  Clinic Name and phone: | | **Does client have an HIV case manager? Indicate agency and name/ contact info for case manager:**  Case manager:  Agency and phone: | | |
| **Estimated Date of Delivery:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Delivery Center:** | | | | |
| **Client signature:** | | | | **Date:** |
| **Please have client sign your system’s release of information and include in fax to 612-813-6770 along with this form**  **Please complete MDH Perinatal HIV reporting form:** [**http://www.health.state.mn.us/divs/idepc/diseases/hiv/perinatal/index.html**](http://www.health.state.mn.us/divs/idepc/diseases/hiv/perinatal/index.html) | | | | Date received by Childrens: |