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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: |