COMPREHENSIVE CLIENT NEEDS SCREENING TOOL: INITIAL

Ryan White Part A: New Orleans EMA
Update: 7/9/10

UIN:_____ **Agency:**_____

Date:_____ **Person(s) screening client:** _____

Note: This tool is for newly infected or new clients to the Ryan White Part A system. Further questions can be directed to Vatsana Chanthala at vchanthala@cityofno.com or (504) 658-2806.

Section A: LINGUISTIC/CULTURAL PREFERENCES

Primary Language: _____

Do you **speak**: ❒ English ❒ Spanish ❒ Other:_____
Do you **read**: ❒ English ❒ Spanish ❒ Other:_____
Do you **write** in: ❒ English ❒ Spanish ❒ Other:_____

Are you currently receiving treatment from a traditional healer (e.g. Curanderos, Faith healers, Acupuncturist, Spiritualist, Voodoo, Other alternative therapy)? ❒Yes ❒No
If yes, please specify: _____

Have your beliefs influenced how you take care of yourself in this illness? ❒Yes ❒No

Are there any other rituals or beliefs that may impact your health care that I need to know? ❒Yes ❒No
If yes, comments_____

As your case manager, how would you like me to address these issues in your care?
_____

Who makes decisions regarding your health in your family? ❒ Self ❒ Other :_____

		Low (1)	Mid (2)	High (3)	Crisis (4)
A	**Linguistic/ Cultural Preferences**	Client can read, write and speak English High level ability to understand the service system(s) and can feel comfortable navigating the systems	Can understand basic English Medium level ability to understand the service system(s) Client has basic reading skills	Can understand some English but also needs interpretation Client cannot read Limited ability to understand service system; may need forms and written materials to be explained	Cannot speak English; needs interpretation services Language or cultural barrier creates distrust/fear/anxiety No understanding of service system

Case Manager: Does client have any service need in this section? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)
_____
_____

Section B: FAMILY AND SOCIAL SUPPORT NETWORK

Have you disclosed to former partner(s) about your HIV serostatus? ❒ Yes ❒ No
Have you disclosed to your current partner about your HIV status? ❒ Yes ❒ No ❒ NA

Are you aware of your current spouse/partner HIV status? ❒ Yes, positive ❒ Yes, negative ❒ No
Describe Relationship: _____
_____

Do you have a social support system that is aware of your HIV status (church, family friend, other)? ❒ Yes ❒ No

If yes, are they supportive? ❒ Yes ❒ No

If no, why?

❒ Disclosure of HIV status will mean loss of home or living arrangements

❒ Client is not ready to disclose HIV status

❒ Other: _____

Do you wish to tell anyone else of your HIV status, but need support in doing so? ❒ Yes ❒ No

If yes, who do you need **help discussing** your HIV status with? _____

Who do you count on or look to for support? (Check all that apply)

❒ No one ❒ Self ❒ Family member ❒ Friend ❒ Spouse/partner

❒ Medical provider ❒ Sponsor ❒ Case manager ❒ Spiritual support person

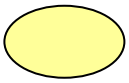
Would you like to have a stronger support system? ❒ Yes ❒ No

Do you attend a support group? ❒ Yes ❒ No

If no, would you be interested in a support group? ❒ Yes ❒ No

If you become unable to care for yourself, is there someone to help you? ❒ Yes ❒ No

If yes, please identify that person: _____

		Low (1)	Mid (2)	High (3)	Crisis (4)
B	**Family & Social Support Network** 	Client has no social support issues	Client has some support network-family/friends/spiritual leaders that can be called on for help	Has few friends/ family who he/she can speak with but not rely on May need routine referral and follow-up	No support system; cannot or will not access supportive relationships

Case Manager: Does client need referral for psychosocial support services? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section C: HOUSING/LIVING SITUATION

In what type of housing do you live? (in the last 6 month)

☐ Permanently Housed
☐ Institutional: Residential (group home, drug treatment, halfway)
☐ Institutional: Health care facility (nursing home, hospice)
☐ Non-permanently Housed: Homeless (shelter, vehicle, street)
☐ Non-permanently Housed: Transitional housing (shelter, short-term hotel/motel, family, friends)
☐ Unknown / Unreported
☐ Other _____

If housed in an institution or non-permanently housed, will you need help with finding shelter or a place to live once discharged? ❒ Yes ❒ No ❒ Na

Are you able to pay for your utilities? ❒ Yes ❒ No

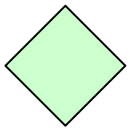
Do you live alone? ❒ Yes ❒ No

If no, with whom do you live? (*Please check*) ❒ roommate ❒ spouse/partner ❒ parents ❒ other relatives

If no, have you disclosed your HIV status to those you live with? ❒ Yes ❒ No

If yes, please list their names and contact info:

Name	Contact Information	Relationship

C	**Housing/ Living Situation*** 	Can live independently Maintains stable /clean housing **Score: 1 x 1= 1**	Some housing instability May need **one-time** short-term assistance with rent/mortgage/ utilities to maintain stable housing **Score: 2 x 2= 4**	Stressful living environment May need ongoing short-term assistance with rent/ mortgage/utilities to maintain stable housing Transitional housing **Score: 3 x 3= 9**	Homeless (i.e shelter, vehicle, street) or imminent eviction Health hazards or harmful living conditions Criminal behavior jeopardizes housing status **Score: 4 x 4= 16**

Case Manager: Does client need referral for housing? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

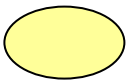
_____

_____

Section D: TRANSPORTATION

What is your main source of transportation?
❒ Own car ❒ Bus ❒ Receive ride from family/friends ❒ Other: _____

Will you need help with transportation to get to your HIV related primary medical care services? ❒ Yes ❒ No

		Low (1)	Mid (2)	High (3)	Crisis (4)
D	**Transportation** 	One or more means of transportation No barrier to transportation	Access to reliable transportation Familiar with taking public transportation system	Multiple barriers to accessing public transportation services	No access to transportation Medical issues affect access to public transportation

Case Manager: Does client need referral for transportation? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

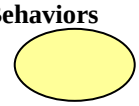
Section E: HIV KNOWLEDGE/HIV RISK BEHAVIORS

Are you sexually active? ❒ Yes ❒ No
If yes, how often do you use a condom or other barrier method? ❒ Never ❒ Sometimes ❒ All of the time.

What methods of risk reduction are you currently using?
❒ Condom/Barrier use ❒ Dental Dams ❒ Abstinence ❒ None ❒ Not applicable

What method (s) of birth control apply to you? *Check all that apply.*

❒Abstinence	❒ Birth control pill	❒ Condoms	❒ Depo Provera
❒ Hysterectomy	❒ IUD/Diaphragm	❒ Spermicide	❒ Tubal ligation
❒ Vasectomy	❒None	❒Not applicable	

		Low (1)	Mid (2)	High (3)	Crisis (4)
E	**HIV Education/ HIV Risk Behaviors** 	Knowledgeable about most HIV behavior change interventions and education services Has skills to maintain healthy life style	Client has adequate knowledge of multiple aspects of HIV treatment and prevention Some difficulty initiating or maintaining protective behaviors	Some level of knowledge about HIV/AIDS Significant difficulty initiating or maintaining protective behaviors History of STDs	Low level of knowledge about HIV/AIDS Client is actively engaging in risk behaviors

Case Manager: Does client need referral for safer sex or family planning? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section F: LEGAL NEEDS

Do you need assistance with any of the following that relates to your HIV condition? (*Please check all that apply*):

❒ Privacy issues ❒ Child Custody ❒ Child Support
❒ Minor guardianship planning ❒ Adoption ❒ Will
❒ Medical power of attorney ❒ Living will ❒ Burial arrangements?
❒ Power of attorney ❒ Discrimination ❒ Notarial services ❒ None Needed

Have you ever been incarcerated? ❒ Yes ❒ No

If yes,

For what: _____

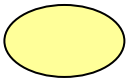
When: _____ Where: _____

If currently on parole/probation, please provide the following:
Parole/probation officer? _____ Phone number: _____

Is your parole/probation officer aware of your HIV Status? ❒ Yes ❒ No ❒ NA

Are you a U.S. citizen? ❒ Yes ❒ No

If no, what documents do you have? ❒ Identification ❒ Residency documents ❒ Visa ❒ None

		Low (1)	Mid (2)	High (3)	Crisis (4)
F	**Legal Needs** 	No legal issues	Needs one time assistance with completing standard legal documents to access services	Needs assistance with getting identification On parole/ probation or has pending court action Needs ongoing follow-up for HIV related legal needs	Lacks pertinent legal documents May not have valid power of attorney needed for immediate clinical decisions May be at risk of dying without a will; guardianship issues for minor children not properly resolve

Case Manager: Does client need referral for legal? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section G: FOOD/NUTRITIONAL ASSESSMENT

Current weight? _____ Height? _____

Have you gained or lost a significant amount of weight in the last 6 months? ❒ Yes ❒ No

If yes, describe this gain or loss and the reason. _____

_____

Are you being treated for a weight problem? ❒ Yes ❒ No

If yes, what is the treatment plan (diet, exercise, medication)? _____

Are you receiving nutritional counseling? ❒ Yes ❒ No

Are you taking nutritional supplements? ❒ Yes ❒ No

If yes, what supplement(s)?_____

Do you have access to: (Please check all that apply)

❒ Food pantry? ❒ Food Stamps? ❒ Meals on Wheels? ❒ Other _____

Do you have any physical problems that make it difficult to eat? ❒ Yes ❒ No

If yes, please check all that apply:

❒ Tooth/mouth problems ❒ Swallowing problems ❒ Food allergies
❒ Nausea ❒ Taste alteration problems ❒ Can not eat certain foods
❒ Other: _____

Are you aware of any health issues that you have that may affect your nutritional status? ❒ Yes ❒ No
If yes, please specify:_____

		Low (1)	Mid (2)	High (3)	Crisis (4)
G	**Food/ Nutritional Assessment**	No food OR nutritional access issue	Some access to food OR some nutritional issues	Unexplained weight change Needs occasional assistance with accessing food or nutritional items	No access to food/nutritional items Lack of access to adequate nutrition interferes with health maintenance of HIV

Case Manager: Does client need referral for nutritional services? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section H: FUNCTIONAL ASSESSMENT (Activities of daily living and home care)

Does your health keep you from working at a job, doing work around the house, or going to school? ❒ Yes ❒ No

The following questions are about activities you might do during a typical day.

Types of activities	I'm limited a lot (√)	I'm limited a little (√)	No, I'm NOT limited (√)
Physical activities you can do, like lifting heavy objects, or running.			
Physical activities you can do, like moving a table, carrying groceries or bowling.			
Walking uphill or climbing a few flights of stairs.			
Bending, lifting or stooping.			
Walking one block.			
Eating, dressing, bathing or getting on and off the toilet.			

Do you need or is currently using any DME? (Example: Cane, walker..etc) ❒ Yes ❒ No

Are you currently receiving home care? ❒ Yes ❒ No
If yes, indicate type (skilled nursing, home health aide, OT, PT)_____

Name of Provider	Address	Phone and Fax	Contact Name

		Low (1)	Mid (2)	High (3)	Crisis (4)
H	**Functional Assessment**	Able to live independently No issues with Activities of Daily Living (ADL)	Needs occasional assistance with ADL	Needs frequent assistance with ADL or home care services	Needs consistent assistance with ADL

Case Manager: Does client need referral for home care? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section I: MEDICAL HISTORY

Date of HIV diagnosis: _____ Date of AIDS diagnosis: _____ ❒ Unknown

Primary Medical Care:

Are you currently seeing a primary care provider for your HIV condition? ❒ Yes ❒ No

If no, why not? _____

_____

If no, would you like for us refer you to a primary care provider? ❒ Yes ❒ No

If no, why not? _____

_____

In the last 6 months, have you gone to the emergency room for HIV condition? ❒ Yes ❒ No

In the last 6 months, have you been hospitalized for reasons/illnesses related to your HIV condition? (an overnight stay)

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

Was client's last **CD_4 <50?** ❒ Yes ❒ No

If yes, has any of the following been done since **CD_4 <50**?

Visit with ophthalmologist ❒ Yes ❒ No ❒ Unknown.

Treatment or MAC Prophylaxis ❒ Yes (ck medication below) ❒ No ❒ Unknown.

❒ Azithromycin (Zithromax)

❒ Clarithromycin (Biaxin)

❒ Rifampin

If client has not been referred to an eye exam and has CD_4 <50, you may want to follow up with his/her primary care provider for refer clients for vision services.

Was patient on PCP Prophylaxis or treatment (CD_4 <200 or 14%) during the review period?

❒ Yes (ck medication below) ❒ No ❒ N/A, CD_4 not <200

❒ Trimethoprim/sulfamethoxazole (Bactrim, Septra, TMP/SMX)

❒ Dapsone

❒ Atovaquone (Mepron)

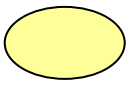
❒ Pentamidine

Clinical Trial History

Have you ever been or are currently on an HIV-related research study or clinical trial (CT)? ❒ Yes ❒ No ❒ unknown

If yes, please indicate sponsor of trial, where/when and description of trial: _____

_____

		Low (1)	Mid (2)	High (3)	Crisis (4)
I	**Medical History** 	Client is fully empowered for self care Stable Health Attends 95% of care appointments Adheres to medical treatment	Stable health but may be some health problems Attends 75% of care appointments May need help accessing medical services	Moderate difficulty managing HIV disease Multiple co-morbidities Out of care for more than 6 months May require coordination of multiple care providers	Serious and severe medical issues Difficulty managing HIV disease Serious HIV related complications Out of PMC for over 12 months or longer Needs complex coordination between multiple providers

Case Manager: Does client need referral for HIV primary care? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section J: MEDICATION/ ADHERENCE

Do you know there are medications to fight HIV infection? ❒ Yes ❒ No

Are you currently taking HIV/AIDS medications? ❒ Yes ❒ No ❒ Unknown

If yes, what HIV medications are you taking? _____

_____

If yes, what is the hardest thing about taking your medications?

❒ Forgetting to take meds or missing dosages.

How many dosages have you missed in the past 7 days?

% adherence: _____ / _____ = _____ %

# of dosages missed total dosage prescribed

❒ Affected by drug side effects
❒ Vision problems
❒ Not taking proper number of meds
❒ Taking meds prescribed for other conditions
❒ Not getting meds due to cost
❒ Coordination of meals/pill taking
❒ Not taking meds on time
❒ Other: _____

If not currently taking HIV medication, have you EVER taken medication for HIV? ❒ Yes ❒ No

If not taking medication, why not? _____

Have you been counseled on how to take your medication and the importance of taking your medication? ❒ Yes ❒ No

If yes, by who? _____ When? _____ Where? _____

If yes, are you comfortable with taking medications according to the instructions provided? ❒ Yes ❒ No

If not comfortable, would you like to learn more about how to take your medications? ❒ Yes ❒ No

Are you taking any herbal medicine or supplements for your HIV disease? ❒ Yes ❒ No

If yes, please describe: _____

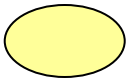
Are you having difficulty <u>getting</u> your medicines? ❒ Yes ❒ No

If yes, please check all reasons that apply:

❒ Don't have transportation
❒ Don't have money
❒ No insurance
❒ Other: _____

Do you have a problem with any of the following? (*Check all that apply*.)

❒ Understanding instructions for taking your medications
❒ Storing medications properly
❒ Keeping medical provider appointments
❒ Adhering to dietary restrictions
❒ Picking up prescription at the pharmacy
❒ Other: _____

		Low (1)	Mid (2)	High (3)	Crisis (4)
J	**Medication/ Adherence** 	Adheres to instructions for HIV medications Takes medications on a regular basis Has >95% adherence	On antiretroviral regimen Has sporadic barriers to adherence Has >85% adherence	On antiretroviral regimen Experiences ongoing barriers to adherence Has less than 70% adherence	Has not taken medications for over 6 months. Not compliant with taking medications. Between 70-85% adherence

Case Manager: Does client need referral for medication adherence? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

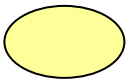
_____

_____

Section K: DENTAL CARE

In the last year, have you had a dental exam? ❒ Yes ❒ No
If yes, who was it by? ❒ Primary care provider or ❒ Dentist ❒Both
If yes, when and where was your last appointment?_____
If no, do you want us to set you up with a dentist? ❒ Yes ❒ No

Do you understand the importance of how healthy dental care is related to your HIV disease? ❒ Yes ❒ No

		Low (1)	Mid (2)	High (3)	Crisis (4)
K	**Dental Care** 	No dental issues	Some dental issues	Experiencing frequent dental issues	Has not had an exam in over 12 months and oral issues interfere with health maintenance of HIV

Case Manager: Does client need referral for dental? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)
_____

_____

Section L: MENTAL HEALTH AND PSYCHOSOCIAL STATUS

Emotional indicators: **Observations:** ***Do not ask client – rather observe and check box next to each symptom or behavior.***

Physical Appearance	Motor	Attitude	Mood	Speech
❒ Underweight	❒ Tremors/tics	❒ Guarded	❒ Sad	❒ Delayed
❒ Poor complexion	❒ Sluggish	❒ Suspicious	❒ Irritable	❒ Excessive
❒ Disheveled	❒ Hyperactive	❒ Hostile	❒ Elevated	❒ Pressured
❒ Visible skin lesions		❒ Belligerent	❒ Anxious	❒ Incoherent

Do you have (Please check all that apply):
❒ Lack of energy ❒ Angry outbursts ❒ Panic attacks ❒ Sleep disturbance
❒ Sadness ❒ Fears ❒ Anxiety ❒ Poor memory
❒ Poor appetite ❒ Nervousness ❒ Change in appetite or stomach problems
❒ Compulsions *(unable to control oneself)* ❒ Obsessions *(constant thoughts about someone or something)*
❒ Hallucinations *(seeing things, hearing things that aren't there)*

Have you ever sought help for any of those problems? Are you receiving help now?
_____

Depression Indicators
During the past 2 weeks, have you been bothered about feeling down, depressed, or hopeless? ❒ Yes ❒ No

During the past 2 weeks, have you often been bothered by little interest or pleasure in doing things? ❒ Yes ❒ No

On a scale from 1-10, with 1 as the worst you've ever felt and 10 as the best you've ever felt, where do you think you are today? _____ Two weeks ago? _____

If you are better or worse today than 2 weeks ago, what has changed in your life? _____

How do you cope with stress?_____

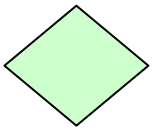
Suicide Indicators
Are you having any thoughts about harming yourself? ❒ Yes ❒ No
If yes, have you thought of a plan to hurt yourself? ❒ Yes ❒ No

Have you tried to hurt yourself before? ❒ Yes ❒ No

Do you think you might hurt yourself today? ❒ Yes ❒ No ; Describe: _____

Do you have pills or weapons in the house? ❒ Yes ❒ No ; Describe: _____

!!! If you think the person might harm him/herself – do not leave client alone, contact your supervisor !!!

L	**Mental Health Psychosocial Status*** 	High level of social functioning No known history of mental health or psychosocial issue(s) **Score: 1 x 1= 1**	History of mental illness, but completed treatment with ongoing counseling Feels down, depressed or hopeless once in a while Needs some individual or group support to deal with HIV status **Score: 2 x 2= 4**	Frequently feels down, depressed or hopeless Needs frequent individual or group support to deal with HIV status **Score: 3 x 3= 9**	Needs immediate psychiatric intervention Extreme disruption of coherent thoughts that interferes with health maintenance of HIV **Score: 4 x 4= 16**

Case Manager: Does client need referral for mental health services? ❒ **Yes** ❒ **No** ❒ **Refused**
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section M: SUBSTANCE USE/ALCOHOL USE

Remind clients: The next set of questions are related to alcohol and substance use. There are no "right" or "wrong" answers. Your responses won't impact whether or not you receive services from our agency.

Have you smoked ≥100 cigarettes in your entire life? ❒ Yes ❒ No
If yes, how often do you smoke cigarettes currently? ❒ Every day ❒ Some days ❒ Not at all
If currently still smoking (every day or some days), have you tried to quit in the last 12 months? ❒ Yes ❒ No
(If no, discuss smoking cessation with client)

Are you **currently** using alcohol or illicit drugs? ❒ Yes, please list:_____ ❒ No
If yes, how often do you use? ❒ Once a week ❒Few days week ❒Every day
If currently still use, have you tried to quit in the last 12 months? ❒ Yes ❒ No

Note to Interviewer: If client is NOT USING, use your judgment on the extent of further questioning. Five questions marked with an *asterisk* are recommended. Otherwise, please proceed to next section of the assessment.

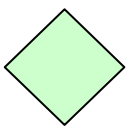
Please circle appropriate answer.

Yes	No	Question
1	0	Have you ever felt that you should cut down on your drinking or drug use?
1	0	Have people annoyed you by criticizing your drinking or drug use?
1	0	Have you ever felt bad or guilty about your drinking or drug use?
1	0	Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?
1	0	*Have you ever gone to anyone for help about your drinking or drug use? *
1	0	*Are you receiving help with your drinking or drug use now?*
1	0	Have you ever been in a hospital because of drinking or drug use?
1	0	Have you or someone else been injured as a result of your drinking or drug use?
1	0	Has your drinking or drug use resulted in trouble with law enforcement?
1	0	Have you had blackouts while drinking? Memory loss?
1	0	*Do you take nerve or pain medications?*
1	0	*Do you find yourself taking more of your nerve or pain medications than your doctor has recommended?*
1	0	*Do you get any nerve or pain medications from someone other than your doctor?*
		Total Score (No = 0 Yes = 1; A total score of 2 or higher is considered clinically significant.)

How has drinking or drug use interfered with your relationships with family/friends?

_____

How about with your job/work? _____

M	**Substance Use/ Alcohol Use*** 	No substance or alcohol or tobacco use issue(s) Successful post-substance use treatment abstinence for over 12 months **Score: 1 x 1= 1**	Minor alcohol (social) intake Smokes socially **Score: 2 x 2= 4**	Active alcohol/ substance use that moderately impacts ability to deal with HIV disease. Smokes some days **Score: 3 x 3= 9**	Current illicit drug use Usage interfere with health maintenance of HIV Current smoker; smokes everyday **Score: 4 x 4= 16**

Case Manager: Does client need referral for substance/alcohol use? ❒ **Yes** ❒ **No** ❒ **Refused**
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

Section N: DOMESTIC VIOLENCE

I'm going to ask some questions related to your relationship with your partner or spouse.

Please circle the appropriate score for each parameter	**Never**	**Rarely**	**Some-times**	**Fairly often**	**Fre-quently**	
How often does your partner physically hurt you?	1	2	3	4	5	
How often does your partner insult or talk down to you?	1	2	3	4	5	
How often does your partner threaten you with harm?	1	2	3	4	5	
How often does your partner physically scream or curse at you?	1	2	3	4	5	**Final Total**
Total Scores						

A final score of greater than or equal to 11 identifies someone as a victimized respondent and a referral to a domestic violence program is advised. The Louisiana Domestic Violence Hotline at (888) 411-1333 can provide assistance in this process.

		Low (1)	**Mid (2)**	**High (3)**	**Crisis (4)**
N	**Domestic Violence**	No domestic violence issue(s)	Not currently being abused but has a history of past abuse	Not currently being abused but has experienced abuse in the past with current house mate	Currently being abused by partner/family member Score of ≥11 on Comprehensive Assessment Form

Case Manager: Does client need referral for domestic violence program? ❒ **Yes** ❒ **No** ❒ **Refused**
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

EMERGENCY EVACUATION PLAN:

In the event of a hurricane/City evacuation, how will client address the following issues?

- ☐ has his/her own transportation
- ☐ will access City of New Orleans 311
- ☐ will leave with agency's transportation system (for clients in housing facility)
- ☐ will leave with family/friends
- ☐ Other:_____

Can client be contacted with the information provided? _____

Where will client go? _____

How will adherence to medications be maintained? _____

Other items reviewed with client regarding emergency evacuation: _____

OVERALL COMMENTS:

_____

_____

Section O: PERINATAL ASSESSMENT (FEMALE ONLY)

Have you seen an OB/Gyn in the last 12 months? ❒ Yes ❒ No, how come? _____

Are you pregnant?

❒ Yes, pregnant

If yes, Are you currently seeing someone for your prenatal care? ❒ Yes ❒ No

If yes, where?

Location: _____ Doctor's Name: _____

Date of last visit _____ When is your next appointment? _____

If no, please refer client:

Location:_____ Appointment date:_____ or ❒ client refused

❒ No, delivered already and child is under 2 years

❒ No, not pregnant (skip to summary section at the end of this page.)

Are you planning on becoming pregnant in the future? ❒ Yes ❒ No

If yes, would you like more information about HIV transmission or risk factors? ❒ Yes ❒ No

Are you aware that you can reduce the risk of passing the virus to your child? ❒ Yes ❒ No

For any woman with a child(ren) who is ≤2 years old, please complete the following to ensure the child is receiving appropriate treatment/care.

Child 1:

What is the child's HIV-status? (check only one) *[Answer based on Lab results]*

❒ Unknown/not tested
❒ Indeterminate
❒ HIV-Positive/clinical and CD4 status unknown
❒ HIV-Negative
❒ Asymptomatic (HIV infected with no symptoms)

If answer is *unknown/not tested or indeterminate* does child need to be tested? ❒ Yes ❒ No ❒Not applicable

If no, refer client- Referral Location: _____ Date:_____

Is your child receiving HIV-related medical care? ❒ Yes ❒ No ❒Not applicable

If yes, where/doctor name and contact information? _____

If no, refer client- Referral location:_____ appointment date:_____ or ❒ client refused

	Low (1)	Mid (2)	High (3)	Crisis (4)
Perinatal Assessment (Female only)	Not pregnant	Client is thinking about getting pregnant	Child was delivered and HIV status is still unknown Client is pregnant	Client is pregnant and has not seen a medical provider for her HIV disease and prenatal care

Case Manager: Does client need referral for OB/GYN/prenatal/HIV care for child? ❒ Yes ❒ No ❒ Refused
If yes, please document referral information (agency, appointment date, and/or, reason referral was unsuccessful.)

_____

_____

TREATMENT ADHERENCE DOCUMENTATION FORM

Update: 6/9/10

Client's UIN: _____ **Case Manager:** _____ **Agency:** _____

Client's medical care provider: _____ **Phone:** _____

LAB Results:

Date									
CD4 #									
CD4 %									
Viral Load									

ANNUAL VACCINATION/SCREENING:

	Flu vaccine	Pap (Female Only)	Dental				
Date Received							
Data source	☐ Self ☐ Lab ☐ CAREWare	☐ Self ☐ Lab ☐ CAREWare	☐ Self ☐ Other:_____ ☐ CAREWare	☐ Self ☐ Lab ☐ CAREWare	☐ Self ☐ Lab ☐ CAREWare	☐ Self ☐ Lab ☐ CAREWare	☐ Self ☐ Lab ☐ CAREWare

MEDICALLY RELATED APPOINTMENTS TRACKING

Appointment with:	Date	Attended?	Notes: (also indicate if info is self-report, or other)
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Vaccination History

Vaccination	Date Received	Re-Vax Date	
Pneumovax			❒ Unknown
Tetanus toxoid or Tdap			❒ Unknown
Hepatitis B vaccine			❒ Unknown
Hepatitis A vaccine			❒ Unknown
Influenza vaccine			❒ Unknown

Other illnesses, diseases, infections and health concerns

Check any that client has experienced or is currently experiencing. Specify if it is current or there is history.

		Current or in the last 12 months	Prior history	Date/Result of test
	Abscesses	❒	❒	
	Epilepsy/seizure disorder	❒	❒	
	Heart disease	❒	❒	
	Endocarditis	❒	❒	
	Hepatitis A	❒	❒	
	Diabetes	❒	❒	
	Kidney disease	❒	❒	
	Hypertension	❒	❒	
	Asthma or COPD	❒	❒	
	Physical disability	❒	❒	
	Chronic diarrhea	❒	❒	
STDs				
	Chancroid	❒	❒	
	Herpes simplex	❒	❒	
	Chlamydia	❒	❒	
	Trichomonas	❒	❒	
	Gonorrhea	❒	❒	
	Bacterial vaginosis	❒	❒	
	Perirectal warts	❒	❒	
	Genital warts	❒	❒	
	Syphilis	❒	❒	
OPPORTUNISTIC INFECTONS: MALIGNANCIES				
	Anal cancer	❒	❒	
	Cervical cancer	❒	❒	
	Kaposi Sarcoma	❒	❒	
	Non-Hodgkin Lymphoma	❒	❒	
	Hodgkin Lymphoma	❒	❒	
OPPORTUNISTIC INFECTONS: PARASITIC INFECTIONS				
	Cryptosporidiosis	❒	❒	
	Isosporiasis	❒	❒	
	Microsporidiosis	❒	❒	
	Cyclosporiasis	❒	❒	
	Amoeba infection	❒	❒	
	Giardiasis	❒	❒	
	Toxoplasmosis	❒	❒	
OPPORTUNISTIC INFECTONS: BACTERIAL INFECTIONS				
	Tuberculosis (TB)	❒	❒	
	Mycobacterium avium complex (MAC)	❒	❒	
	Bacterial pneumonia	❒	❒	
	Nocardia infection	❒	❒	

		Current or in the last 12 months	Prior history	Date/Result of test
	Staph infections	❒	❒	
	Bacillary angiomatosis	❒	❒	
OPPORTUNISTIC INFECTONS: VIRAL INFECTIONS				
	CMV	❒	❒	
	Hepatitis B - **circle one: chronic or previous**	❒	❒	
	Hepatitis C - **circle one: chronic or previous**	❒	❒	
	Herpes zoster virus (“shingles”)	❒	❒	
	Molluscum contagiosum	❒	❒	
	Oral hairy leukoplakia	❒	❒	
	Progressive multifocal leukoencephalopathy (PML)	❒	❒	
OPPORTUNISTIC INFECTIONS: FUNGAL				
	Esophageal candidiasis	❒	❒	
	Pneumocystosis (PcP)	❒	❒	
	Thrush (oral candidiasis)	❒	❒	
	Vaginal yeast infections	❒	❒	
	Histoplasmosis	❒	❒	
	Cryptococcosis	❒	❒	
	Coccidioidomycosis	❒	❒	
	Aspergillosis	❒	❒	
NEUROLOGICAL CONDITIONS				
	AIDS dementia complex (ADC)	❒	❒	
	Peripheral neuropathy	❒	❒	
	Post-herpetic Neuralgia	❒	❒	
OTHERS				
	Aphthous ulcers (“canker sores”)	❒	❒	
	Thrombocytopenia (low platelets)	❒	❒	
	Anemia (low red blood cells)	❒	❒	
	Leukopenia (low white blood cells)	❒	❒	
	Wasting syndrome	❒	❒	
	Depression	❒	❒	

What are some past and present health concerns related to your HIV disease