

# Care Coordination Program Referral Form

INFECTIOUS DISEASE DISCHARGE SUMMARY Page 1 of 2

Fax copy to: (804) 864-8050

Care Coordinator Phone Number: 804-864-7919

CLIENT INFORMATION		
<b>Name:</b>	<b>DOB:</b>	<b>ID Number:</b>
<b>DOC/JAIL Facility NAME:</b>	<b>SSN:</b>	<b>Race:</b>
<b>Ethnicity:</b> Non-Hispanic <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>	<b>Release Date:</b>
<b>Home Address:</b>	<b>Phone Number:</b>	

DISCHARGE INFORMATION	
<b>Medical Provider Name:</b>	<b>Phone Number:</b>
<b>Medical Provider Address:</b>	<b>Scheduled Appointment Date/Time:</b>
<b>Case Manager Name:</b>	<b>Phone Number:</b>
<b>Health Department where client wants to pick up medications upon release:</b>	

LINKAGE TO CARE AND SERVICES			
<b>List special counseling or treatment programs that client may need upon release.</b>  (i.e. Substance Abuse/Mental Health)	1.		
	2.		
	3.		
<b>Has stable housing for first night of release?</b>	<b>YES</b>	<b>NO</b>	<b>Unknown</b>
<b>Is client currently adherent to drug regimen?</b>	<b>YES</b>	<b>NO</b>	<b>Unknown</b>
<b>Is client currently blind or disabled?</b>	<b>YES</b>	<b>NO</b>	

**Additional Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INFECTIOUS DISEASE DISCHARGE SUMMARY Page 2 of 2**

<b>CLIENT NAME:</b>	<b>DOB:</b>
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CURRENT LAB VALUES			
<b>CURRENT DISEASE STATUS:</b>			
<input type="checkbox"/> HIV Positive, not AIDS <input type="checkbox"/> HIV Positive, AIDS status unknown <input type="checkbox"/> CDC-defined AIDS <input type="checkbox"/> Pediatric			
<b>Most Current CD4 Count:</b>		<b>DATE:</b>	
<b>Most Current CD4 Percentage:</b>		<b>DATE:</b>	
<b>Most Current HIV Viral Load:</b>		<b>DATE:</b>	

INFECTIOUS DISEASE HISTORY			
INFECTIOUS DISEASE:	YES	NO	DATE DIAGNOSED
<b>HIV/AIDS:</b>			
<b>HEPATITIS C:</b>			
<b>HEPATITIS B:</b>			

CURRENT MEDICATIONS		
Name of HIV-Related Medication/s:	Released with Medication upon release:	Amount of Medication supply provided at release: (total # of days)
1.	Yes    No	
2.	Yes    No	
3.	Yes    No	
4.	Yes    No	
5.	Yes    No	
Name of other Current Medications		
1.	Yes    No	
2.	Yes    No	
3.	Yes    No	
4.	Yes    No	
5.	Yes    No	
6.	Yes    No	
7.	Yes    No	
8.	Yes    No	
9.	Yes    No	

**FORM COMPLETED BY:**

<b>Printed Name:</b>	<b>Direct Phone:</b>	<b>Extension:</b>
<b>Signature:</b>	<b>Business Cell:</b>	<b>Fax:</b>

## AUTHORIZATION TO EXCHANGE AND DISCLOSE HEALTH INFORMATION

I understand that different agencies provide different services and benefits and that each agency must have specific information to provide those services and benefits. By signing this form, I allow agencies to use and exchange certain information, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

PRINT RETURNING CITIZEN'S FULL NAME

DOB (MM/DD/YYYY)

I want the following confidential information to be exchanged (Please check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Benefits/ Services Needed Planned, and/or Received | <input type="checkbox"/> Medical Records                     |
| <input type="checkbox"/> Contact Information After Discharge                | <input type="checkbox"/> Mental Health Diagnosis             |
| <input type="checkbox"/> Criminal Justice Records                           | <input type="checkbox"/> Psychological Records               |
| <input type="checkbox"/> Laboratory Results                                 | <input type="checkbox"/> Substance Use History and Treatment |
| <input type="checkbox"/> Medical Diagnosis                                  | <input type="checkbox"/> All of the Above                    |

To receive services, resources and/or additional assistance through the Virginia Department of Health, community agencies or medical facilities (Please check all that apply):

### COMPREHENSIVE HIV/AIDS RESOURCE AND LINKAGES FOR INMATES (CHARLI) PROGRAM:

- Thomas Jefferson Health District - Charlottesville, VA
- Council of Community Services - Roanoke, VA
- Fan Free Clinic - Richmond, VA
- Minority AIDS Support Services - Newport News, VA
- Inova Juniper - Northern VA

### PATIENT NAVIGATION:

- Carilion, Infectious Disease Clinic - Roanoke, VA
- Virginia Commonwealth University, Infectious Disease Clinic - Richmond, VA

### OTHER:

- Virginia Department of Health - Richmond, VA

(PRINT THE AGENCY AND/OR PROGRAM IF IT IS NOT LISTED ABOVE)

This authorization is good until:

My service case is closed.

Other \_\_\_\_\_

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed. However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s):

\_\_\_\_\_  
(AUTHORIZATION PERSON OR PERSONS)

\_\_\_\_\_  
(DATE)

Person Explaining Form:

\_\_\_\_\_  
(NAME)

\_\_\_\_\_  
(CORRECTIONAL FACILITY OR ORGANIZATION)

\_\_\_\_\_  
(PHONE NUMBER)

Witness (If Required):

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(ADDRESS)

\_\_\_\_\_  
(PHONE NUMBER)