Care Coordination Program Referral Form

INFECTIOUS DISEASE DISCHARGE SUMMARY **Page 1 of 2**

Fax copy to: (804) 864-8050

Care Coordinators:
804-864-7951
804-864-7246

CLIENT INFORMATION		
Name:	**DOB:**	**ID Number:**
DOC/JAIL Facility NAME:	**SSN:**	**Race:**
Ethnicity: **Non-Hispanic** ☐ **Hispanic/Latino** ☐ **Unknown** ☐	**Gender:** **Male** ☐ **Female** ☐ **Transgender** ☐	**Release Date:**
Home Address:	**Phone Number:**	

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

LINKAGE TO CARE AND SERVICES			
List special counseling or treatment programs that client may need upon release. **(i.e. Substance Abuse/Mental Health)**	**1.** **2.** **3.**		
Is client currently enrolled into Medicaid?	**YES**	**NO**	**Unknown**
Is client currently blind or disabled?	**YES**	**NO**	**Unknown**
Is client currently adherent to drug regimen?	**YES**	**NO**	**Unknown**
Does client have stable housing for the first night after release?	**YES**	**NO**	**Unknown**

Additional Notes: _____
_____

CLIENT NAME:	DOB:

CURRENT LAB VALUES

CURRENT DISEASE STATUS:

☐HIV Positive, not AIDS ☐HIV Positive, AIDS status unknown ☐CDC-defined AIDS ☐Pediatric

Most Current CD4 Count:		**DATE:**	
Most Current CD4 Percentage:		**DATE:**	
Most Current HIV Viral Load:		**DATE:**	

INFECTIOUS DISEASE HISTORY

INFECTIOUS DISEASE:	YES	NO	DATE DIAGNOSED
HIV/AIDS:			
HEPATITIS C:			
HEPATITIS 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	

ADDITIONAL HEALTH INFORMATION

Have you used tobacco products in any form prior to incarceration?	☐ Yes ☐ No
If, Yes please provide the type, amount of tobacco used, and frequency?	

FORM COMPLETED BY:

Printed Name:	**Direct Phone:**	**Extension:**
Signature:	**Business Cell:**	**Fax:**

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 INMATE'S FULL NAME _____ DOB (MM/DD/YYY) _____

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

- ☐ Benefits/Services Needed Planned, and/or Received
- ☐ Contact Information After Discharge
- ☐ Criminal Justice Records
- ☐ Laboratory Results
- ☐ Medical Diagnosis
- ☐ Medical Records
- ☐ Mental Health Diagnosis
- ☐ Psychological Records
- ☐ Substance Use History and Treatment
- ☐ 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)* *(PHONE NUMBER)*

Witness (If Required): _____

(SIGNATURE) *(ADDRESS)* *(PHONE NUMBER)*

Revised 07/2015