VA MAP ADDITIONAL 30-DAY MEDICATION REQUEST FORM

PATIENT NAME (Last, First, MI):	REQUEST DATE:
D.O.B (MM/DD/YY):	SEX: ☐ MALE ☐ FEMALE
PATIENT TELEPHONE NUMBER:	
MEDICATION (S) REQUESTED:	QUANTITY:
IS CLIENT AN ACTIVE VA MAP CLIENT? ☐ YES ☐ NO	REASON FOR REQUEST:
PROVIDER NAME:	PHONE NUMBER: FAX:
LOCAL HD VA MAP CONTACT PERSON:	PHONE NUMBER: FAX:
FORM COMPLETED BY (NAME):	PHONE NUMBER:

MOST RECENT VIRAL LOAD RESULTS	DATE	MOST RECENT CD4 COUNT RESULTS	DATE

LAST VA MAP ELIGIBILITY DATE:

VA MAP USE ONLY

☐ Request Approved ☐ Request Denied

Notes:____

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Signature:_______________________________ Date:_______________

Fax to CENTRAL VA MAP office, VA MAP Coordinator at (804) 864-8050

FORM UPDATED: 08/2019