

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 <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>	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:

INFECTIOUS DISEASE DISCHARGE SUMMARY Page 2 of 2

CLIENT NAME:	DOB:
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CURRENT LAB VALUES			
CURRENT DISEASE STATUS:			
<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			
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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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 or Received | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Contact Information After Discharge | <input type="checkbox"/> Mental Health Diagnosis |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Psychological Records |
| <input type="checkbox"/> Medical Diagnosis | <input type="checkbox"/> Substance Use History and Treatment |
| <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 RESOURCES AND LINKAGES FOR INMATES (CHARLI) PROGRAM:

- Council of Community Services - Roanoke, VA
- Health Brigade (formerly Fan Free Clinic) - Richmond, VA
- Inova Juniper - Northern, VA
- Minority AIDS Support Services - Newport News, VA
- University of Virginia - Charlottesville, VA

PATIENT NAVIGATION:

- 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 _____

To revoke this authorization, check box, sign and date. _____

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): _____

(PERSON AUTHORIZING RELEASE OF INFORMATION)

(DATE)

Person Explaining Form: _____

(NAME)

(CORRECTIONAL FACILITY)

(PHONE NUMBER)

Witness (if required) _____

(SIGNATURE)

(ADDRESS)

(PHONE NUMBER)