Hassle Free Men's & Trans* Clinic

Making the Links: HIV Aftercare & Follow-up

Contact Information

Full Name: **Date of Birth:**

Resident of: □ Toronto □ GTA □ Other: _____

Tel: **Can we leave a voice message?** □ **YES** □ **NO**

Email:

HIV Test Information

Date of Reactive Test: **Test Site:**

Date of Confirmatory Result Pick-up:

HIV Primary Care Physician Referral

HIV Knowledgeable Doctor:

☐ **YES**: _____ ☐ **NO:**

☐**Referral made to:** _____

☐**Making the Links Counsellor to make the referral.**

☐ **Referral declined.**

Consent to Release Contact Information

I, _____ consent to the release of my contact information for the purpose of being referred to HIV-related primary care and community services following anonymous HIV testing. I understand that once I complete my HIV blood work with a primary care physician, my HIV status will be noted in my medical record.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Progress Note

Date	

Making the Links: HIV Aftercare Psychosocial Assessment

Appointment Date: DD/MM/YYYY ☐In-person ☐Over the phone

Doctor

HIV/ID Specialist:	☐YES: Full Name ☐ NO, Referral made to:
	Has an appointment been booked? ☐YES: DD/MM/YYYY ☐ NO

Source of Income	Services Desired	Comments
☐ Full-time work: _____ ☐ Part-time work: _____ ☐ Social Assistance: ☐ OW ☐ODSP ☐ Private Insurance/Disability ☐ None	☐Employment Services ☐*Referred to ACT* ☐Income Support Assistance ☐*Referred to PWA*	**Follow-up:** ☐ **Yes,** DD/MM/YYYY ☐ **No**

Medical/Drug Coverage	Services Desired	Comments
☐Private Insurance: % _____ ☐Ontario Drug Benefit Card ☐None	☐Ontario Trillium Drug Coverage ☐*Referred to PWA* ☐Complimentary Therapies (e.g. Yoga, Naturopathic Doctor, etc) ☐*Referred to PWA*	**Follow-up:** ☐ **Yes,** DD/MM/YYYY ☐ **No**

Emotional Support	Services Desired	Comments
☐Friends ☐Family ☐Partner ☐ Psychotherapist: _____ ☐ Religious or Spiritual Leader /Affiliation: _____ ☐Support Group: _____ ☐ Peer support ☐Substance-related support: _____	☐Short-term Individual Counselling *Referred to:* ☐ *Making the Links* ☐ *519* ☐Long-term Individual Counselling *Referred to:* ☐ *DKS* ☐*ACT* ☐*Mount Sinai* ☐Support Groups ☐*Referred to ACT* ☐ Peer Support ☐ *Referred to ACT - Buddy Program* ☐ *Referred to ACT - Positive Youth Outreach,* ☐ Substance Treatment Program ☐*Referred to CAMH Rainbow Services* ☐Ethno-cultural Social Support: *Referred to:* ☐*Black CAP* ☐*ACAS* ☐*ASAA* ☐ *CFSSP* ☐ *APAA*	**Follow-up:** ☐ **Yes,** DD/MM/YYYY ☐ **No**

Progress Notes

☐ **Follow-up care refused**	☐ **Date & time of follow-up appointment:** DD/MM/YYYY @ TIME

Staff Signature: _____