Providence HEALTH CARE

IMMUNODEFICIENCY CLINIC
FIRST CONTACT ASSESSMENT

Date: _____

PATIENT CONTACT DETAILS

Patient phone number: _____ ☐ OK to leave messages

Patient address: _____ ☐ OK to send letters

_____

Emergency Contact: _____ ☐ OK to phone

_____ Is contact aware of patients HIV status

_____ ☐ Yes ☐ No

To be completed by Social Work:

Date of Diagnosis: _____ ☐ Transfer - Previous provider: _____

☐ New Diagnosis HIV risk factor: _____

Referral Source: _____

Reason for referral: _____

MSP/health Insurance: ☐ No ☐ Yes - PHN: _____ **Ethnic origins:** _____

Relevant physical / psychological issues since diagnosis:

Any urgent health problems today?

Any urgent mental health/addiction issues today?

If transferring care, is there recent blood work? Date: _____

CD4: _____ HIV viral load: _____

Is the patient on ARVs? ☐ No ☐ Yes If yes, specify: _____

Other medications: _____

Type of accommodation

- ☐ House / Apartment
- ☐ Dr Peter Centre Residence
- ☐ Other long term Care
- ☐ NFA
- ☐ Single Room Occupancy
- ☐ Shelter
- ☐ Treatment / recovery House
- ☐ Staying with family/friend

Social Support and Service Utilization

- ☐ Partner / Family / Friends
- ☐ Home care / Home support
- ☐ HIV / Aids Service Organization
- ☐ Outreach
- ☐ HIV Support Group
- ☐ Positive Outlook Program
- ☐ Dr Peter Centre Day care Program
- ☐ Case Manager:
- ☐ Other:

Employment / Income Information

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Social assistance (welfare)
- ☐ Retired Pensioner
- ☐ Disability, income (PWD, CPP, etc.)
- ☐ Financial support from partner / family
- ☐ Other:

Present Legal Status

- ☐ Canadian citizen
- ☐ Landed immigrant (permanent resident)
- ☐ Indian Affairs (First Nations status)
- ☐ Refugee Claimant
- ☐ Convention Refugee
- ☐ Other:

Signature: _____ Printed name: _____

First Contact Nursing Appointment Date: _____ Time: _____

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Date: _____

To be completed by Nursing:

☐ **HIV antibody document** Date of last negative HIV test: _____

How do you usually deal with stressful situations? _____

Have you experienced any losses/changes/traumatic events that are still affecting you? _____

CLINIC ORIENTATION (Tick if discussed)

Orientation to clinic: (Verbal)

- ☐ Multidisciplinary team
- ☐ Clinic hours
- ☐ After hours / weekend
- ☐ Lab hours and location
- ☐ Patient Advisory Group

Self-care:

- ☐ CD4 / VL
- ☐ Blood requisitions Q1 to 2 monthly at lab, prior to clinic visit
- ☐ Nurses appointments: Once per month; vaccines, yearly PAP/STI
- ☐ Regular Doctor appointments
- ☐ HIV education and support services

Consent forms:

- ☐ Transfer letter (if applicable)
- ☐ GP Consent form
- ☐ Centre for Excellence
- ☐ PharmaNet Consent (verbal)

Tests / Date:

B/P: _____

Weight: _____ kg

Height: _____ cm

Last PAP: _____

Last STI Screen: _____

Blood taken today for:

- ☐ Routine HIV
- ☐ Hep A/B/C, toxoplasmosis
- ☐ Urine Drug Screen (if applicable)
- ☐ Urinalysis (Alb/Cr)
- ☐ RPR
- ☐ HLA B5701
- ☐ HIV resistance/genotype (fax)
- ☐ Other:

Previous results:

HBsAg: _____

HBsAb: _____

HBcAb: _____

AntiHAV: _____

HCVAb: _____

Toxoplasmosis: _____

RPR: _____

HLA-B5701: _____

Vaccination History:

- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Tetanus/Diptheria Date: _____
- ☐ TB Skin test Date: _____
- ☐ Pneumococcal Date: _____
- ☐ Seasonal Influenza Date: _____
- ☐ Waiting for transfer of records

Follow-up Appointments	Date	Time
Doctor: _____		
Nurse: _____		
Social Worker: _____		
Addictions Counselor: _____		

Signature: _____ Printed name: _____