Department of Health
Three Capitol Hill
Providence, RI 02908-5097
401-222-2577
TTY: 771
www.health.ri.gov

Out of Care Referral Form for HIV Patients

The Rhode Island Department of Health has been funded by the Centers for Disease Control and Prevention to improve the health of persons with HIV by locating and re-engaging patients lost to care and retaining them in care long-term. Please complete this form for HIV-positive patients who have not been seen by your staff in the last 6 or more months - or sooner if your client/patient is at an increased risk of being lost to HIV medical care and cannot be located by your staff, or if there is other reason for concern. Thank you for working with us to ensure that people with HIV are successfully engaged with the appropriate medical care.

Please complete one form per patient and MAIL (DO NOT FAX) as patients are identified to:
Attn: Return To Care Program **(CONFIDENTIAL)**
Center for HIV, Hepatitis, STDs, and TB Epidemiology
3 Capitol Hill Room 106
Providence, RI 02908

RI State Number: _____
(internal use only)

Person completing form: _____ **Date of referral:** _____/_____/_____
Person to be contacted for follow up: _____
Reporting facility: _____ **Telephone number:** _____-_____-_____

First Name: _____ **MI**: ____ **Last Name:** _____
DOB: _____/_____/_____ **SSN:**_____-_____-_____

Last known address: _____ ☐ Not Available

Last known telephone number (home or cell): _____ ☐ Not Available

Current Gender:
- ☐ Male
- ☐ Female
- ☐ Trans F-to-M
- ☐ Trans M-to-F
- ☐ Other

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

Race:
- ☐ American Indian /AK Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native HI/ Other Pacific Islander
- ☐ White
- ☐ Unknown

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

PLEASE COMPLETE ALL OF THE FOLLOWING:

Date of last appointment known with **case management** services: _____/_____/_____
› Case management service provider: _____
Date of last known **contact** with client: _____/_____/_____
Date of **last attempt to contact** patient via phone or mail: _____/_____/_____

Date of last **appointment** with medical provider: _____/_____/_____
› Provider Name: _____
Date of last **CD4/viral load labs** drawn at your facility: _____/_____/_____

Date of last **pharmacy** pick up: _____/_____/_____

▶ **Reason for Referral** & Comments (e.g., other services patient is receiving, comorbidities, pharmacy name):

_____
_____
_____