Referral Form

STOP Outreach Team
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Client Information			**Referral Date:** (dd/mmm/yyyy)
Last Name:	**First Name:**		**PID:**
Gender: ❒ **F** ❒ **T** ❒ **M** ❒ **Other**	**Date of Birth:** (dd/mmm/yyyy)	**Ethnicity:**	**PHN:**
Permanent Address: ❒ Unknown		**Phone #**	**Language Details:**
Current Location and Contact Details: ❒ Unknown			

Referral Source Details		
Organization Name	Contact Name	Contact Number

Reason for Referral

❒ **New HIV+** Engage client in care ❒ **Known HIV+** Re-Engage client (Lost to Care) ❒ **Known HIV+** Strengthen client engagement in care

Client Status		**Date**	**Comment**
Primary Care Provider:		Date of last visit	
CD4 # and %:			
pVL #:			
On ARVs? ❒ Yes ❒ No	**Adherence issues?** ❒ Yes ❒ No	Date on ARV's	

Social & Community Supports (Name/Organization)	**Nature of Involvement/Support**	**Contact Number:**

Additional Details/Services Requested: