AIDS PROJECT LOS ANGELES — HOME HEALTH REFERRAL

PERSONAL INFORMATION

Name: Last_____ First_____ Middle_____ Date_____

Social Security #_____ Date of birth_____ AP #_____

Address_____ City_____ Zip_____

Phone #1_____ Best Time To Call_____ ☐ Message OK ☐ No APLA Id

Phone #2_____ Best Time To Call_____ ☐ Message OK ☐ No APLA Id

☐ Male ☐ Female ☐ Transgender ☐ English Speaking ☐ Monolingual Spanish ☐ Other_____

☐ APLA Registered Client ☐ Needs Full APLA Intake Income_____

Referred by_____ Phone_____

Comments_____

OTHER CONTACT / RELATIONSHIP

Contact_____ Relationship_____

Phone #_____ Best Time To Call_____ ☐ Message OK ☐ No APLA Id

☐ Emergency Contact ☐ Lives With ☐ Disclosure Permitted

CURRENT MEDICAL INFORMATION

Medical Provider_____ Organization_____ Phone_____

Insurance:_____

☐ Symptomatic ☐ HIV ☐ AIDS

Status:
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Fevers
- ☐ Lymphadenopathy
- ☐ CD4 < 200
- ☐ Neuropathy

☐ Opportunistic Infections
- ☐ KS
- ☐ PML
- ☐ PCP
- ☐ MAC
- ☐ CMV
- ☐ Wasting
- ☐ Other:_____

☐ Cancer: _____
- ☐ Cardiovascular/Respiratory Problems
- ☐ Cognitive/Memory Impairment
- ☐ GI/GU Problems
- ☐ TB (On Treatment ☐ Yes ☐ No)
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ Vision/Hearing Impairment

Comments_____

CARE CONCERNS / CURRENT NEEDS

☐ Assistance Needed:
- ☐ Bathing/Grooming/Dressing
- ☐ Ambulation
- ☐ Meal Preparation/Feeding
- ☐ Toileting
- ☐ Medication Reminders
- ☐ Light Housekeeping
- ☐ Accompany to Medical Appts.

☐ Current Psychosocial Issues (describe)
- ☐ Mental Health_____
- ☐ Substance Abuse_____
- ☐ Housing_____
- ☐ Benefits/Legal_____

Comments_____

DISPOSITION (Completed By Home Health Staff Only)

Medi-Cal Verified ☐ Yes ☐ No Share Of Cost_____ Team Assigned_____

AEVS Number _____ Date Assigned_____