MARYLAND LHD HIV SERVICES REQUEST FORM FOR LINKAGE TO CARE & PARTNER SERVICES

Affix Maryland HIV Testing Encounter Form Sticker Here, if available

If Not Tested, check here ☐

Client has requested and/or consented to these services → Counselor initials: _____

CLIENT CONTACT & DEMOGRAPHIC INFORMATION

First Name / and Aliases	M.I.	Last Name / and Aliases

Current Address	Social Security Number
	- -

City	State	Zip Code	Date of Birth
			/ /

Home Phone	Cell Phone	Text Message?	Primary Language: ☐ English
( ) -	( ) -	☐ Yes ☐ No	☐ Spanish ☐ _____

Work / Company Name & Address	Work Phone
☐ Unemployed ☐ Unknown	( ) -

Best Time / Method of Contact:

Time: ☐ Morning ☐ Midday ☐ Evening ☐ Actual Time: _____ Circle: AM PM

Method: ☐ Phone – Circle: CELL HOME WORK ☐ Address – Circle: HOME WORK

Ethnicity	Race (mark all that apply)	Gender Identity	Pregnant?	Relationship Status
☐ Hispanic ☐ Not Hispanic ☐ Don't Know	☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Don't Know	☐ Male ☐ Female ☐ Transgender ☐ Transgender – M to F ☐ Transgender – F to M	☐ Yes ☐ No ☐ Don't Know **In Prenatal Care?** ☐ Yes ☐ No	☐ Single ☐ Steady relationship(s) ☐ Married ☐ Divorced

EMERGENCY CONTACT INFORMATION

First Name	Last Name	Relationship to Client →	Aware of Status
			☐ Yes ☐ No

Phone Number		Address
( ) -	☐ Home ☐ Work ☐ Cell ☐ Other	

PREVIOUS DIAGNOSIS & MEDICAL CARE HISTORY

Date of First Diagnosis	Provider / Facility (Name, Phone Number)	
/ /		☐ Patient Self-Report ☐ Information Verified

Date of Last Care Appointment	Provider / Facility (Name, Phone Number)	
/ /		☐ In Care ☐ Out of Care ☐ Self-Report ☐ Verified

REQUESTING AGENCY INFORMATION

Name of Person Submitting this Request	Direct Phone Number	Date Tested / Encountered
	( ) -	/ /

Name of Agency Submitting this Request	PHPA Site Number	Date Request Sent to LHD
		/ /

OTHER NOTES OR LOCATING INFORMATION

Email Address, Screen Name, Additional Phone Numbers, Physical Description, Partner Names, etc.

SERVICES NEEDED

Mark all that apply:

- ☐ Linkage to Medical Care
- ☐ Partner Notification

  If previous positive:
  - ☐ STI Screen / Treat
  - ☐ Sero-Discordant Partner
  - ☐ Notify New Partner

INSTRUCTIONS FOR COMPLETING & SUBMITTING THE

MARYLAND LHD HIV SERVICES REQUEST FORM FOR LINKAGE TO CARE & PARTNER SERVICES

Providers should use this form to request local health department (LHD) assistance for or on behalf of their HIV-positive patients. Upon receipt, trained local health department DIS or other linkage to care staff will contact the person who submitted the request to verify receipt and/or obtain additional information when necessary.

Maryland law specifies that when an individual tests HIV-positive, the physician or physician's designee must refer the individual to HIV medical care and provide assistance with notifying partners.

This form can and should be used by public or private providers, community-based HIV testing staff, local health department clinical staff, HIV case managers, and any other service provider who works with persons living with HIV who need assistance with linkage, re-linkage, or engagement in HIV medical care, and/or partner services.

NOTE: If the client was NOT tested, please check "If Not Tested, check here" box in the top right corner. If the client was tested, don't forget to attach the Maryland HIV Testing Encounter Form sticker over the text in the top right corner.

INSTRUCTIONS FOR COMPLETING FORM ** **PLEASE PRINT USING CAPITAL LETTERS** **

CLIENT CONSENT TO REFERRAL

At the top of the form please write your initials in the space provided to indicate that the client has requested and/or consented to the referrals indicated on this form. Your initials signify that you have explained to the client that the LHD will follow-up to contact them using the information provided (including, if necessary, the emergency contact).

CLIENT CONTACT & DEMOGRAPHIC INFORMATION

Provide the client's full name, current (residential) address, social security number, and date of birth as it has been reported to the provider. Enter home and cell phone numbers at which the client may be reached (mark 'Yes' if the LHD can text message the patient). Identify the patient's primary language so the LHD can arrange for an interpreter if necessary. Provide information regarding when / where the client prefers to be contacted by the LHD.

EMERGENCY CONTACT INFORMATION

If the client cannot be reached using the provided address and phone numbers, the LHD will attempt to reach the emergency contact to locate the client. Be sure to ask for this information and explain how / when it will be used.

PREVIOUS DIAGNOSIS & MEDICAL CARE HISTORY (if applicable)

Document the date and provider or facility of your client's first / original HIV diagnosis. Provide the date and provider or facility of your client's last HIV medical care appointment and indicate if your client is currently in care.

REQUESTING AGENCY INFORMATION

The LHD may call you for further information prior to contacting your client. Enter the name of the person making this referral, his/her direct phone number, and the date the client was tested or encountered. Provide the name of the agency submitting this request, their 4-digit HIV Testing Site number (if applicable), and the request date.

OTHER NOTES OR LOCATING INFORMATION

Provide any additional information, which may be helpful to the LHD in contacting and locating this individual or their partners – such as notes related to your encounter, partners the client/patient named or came in with, etc.

SERVICES NEEDED

Identify which services are requested. If the client was previously diagnosed with HIV and needs assistance with partner notification please indicate this in the space provided. This will help the LHD assign appropriate staff.

SUBMISSION OF FORM TO THE LOCAL HEALTH DEPARTMENT

WHAT If not tested, submit only the completed "Maryland LHD HIV Services Request Form".
If tested, also submit the lab slip and photocopies of the HIV Testing Encounter/Intake Form.

HOW Submit the completed forms to the local health department via US Mail. DO NOT FAX THESE FORMS.

COPY Keep a copy of this form in the patient's chart / file for your records.

QUESTIONS… Contact Marcia Pearl, PHPA, HIV Partner Services at (410) 767-5084 or BCHD 410-396-4448.