

# Referral to Specialty Care

Date of referral: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## REFERRING HEALTH CARE PROVIDER

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Patient:** \_\_\_\_\_

DOB: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_

Policy ID#: \_\_\_\_\_

## REFERRED TO HIV SPECIALIST

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Contact Person (if not patient):

Name: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Type of test:  Rapid  Conventional

Date of HIV test result: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### \*Attach Lab Antibody Test Result

Current symptoms (if any):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chronic medical conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature - Health care provider

\_\_\_\_\_  
Signature - Patient