LINKAGE AND RE-ENGAGEMENT PROGRAM REFERRAL FORM

County of Los Angeles Public Health
Division of HIV and STD Programs

Referring HIV Clinic Contact Information

Secure Fax Instructions: An official clinic fax coversheet must accompany the Referral Form, no Patient Identifying Information can be included on the coversheet

LRP Secure Fax Number: 1-213-382-7605 **Attention to:** _____
LRP Provider Phone Line: 1-213-639-4288

Referring HIV Clinic Contact Information

Client Casewatch ID #: _____ Date of Referral: _____

HIV Medical Clinic Name: _____ Address: _____

Staff Name: _____ Phone: _____ ☐ Office ☐ Cell

Staff Title: _____ Email Address: _____

Patient Contact Information

Patient Last Name: _____ First Name: _____ Middle Initial: _____

AKAs: _____ Race/Ethnicity_____

Date of Birth: _____ Gender: ☐ Male ☐ Female (If yes, pregnant? ☐ Yes ☐ No)

Monolingual Spanish-Speaker? ☐ Yes ☐ No ☐ Transgender

Physical Description: _____

Last Known Address: _____

Phone Number: _____ ☐ Home ☐ Cell Alternate Phone Number: _____ ☐ Home ☐ Cell

Email Address: _____ SS#: _____ Medical Record #: _____

Patient's Emergency Contact (E/C) Information: ONLY LIST IF E/C IS AWARE OF PATIENT'S HIV STATUS
Name: _____ Phone: _____ Email: _____

Last HIV Medical Appointment Date: _____ Last VL Count: _____ copies/mL VL Date: _____

Contact Attempts Made

Phone Call(s) and Text Message(s) – Must have attempted at least 3 times within 2 weeks over the past 30 days

Phone Number Attempted: _____ Alternate Phone Number Attempted: _____

Dates Attempted: (1st) _____ (2nd) _____ (3rd) _____

Results? ☐ Wrong Number ☐ Disconnected ☐ No Response ☐ Declined services at clinic

Letter Mailed to Last Known Address – Must have mailed 1 letter within the past 30 days ☐ Yes ☐ No

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Date Mailed: _____

Home Visit(s) – Must have conducted at least 1 home visit over the past 30 days after a letter was mailed and not returned back to sender

Home Visit(s) Conducted? ☐ Yes ☐ No Date(s): _____

Results? ☐ Not Home ☐ Doesn't Live There ☐ No Such Address/Address Invalid

Email(s) sent? ☐ Yes ☐ No Date(s): _____

Results? ☐ Email Returned ☐ No Response

Other Services within the Clinic/Organization Contacted? ☐ Yes ☐ No
If Yes, where? If No, why not? _____

Checked LASD Inmate Locator? ☐ Yes ☐ No **Results?** ☐ Not Incarcerated ☐ Patient Incarcerated
Notes: _____

Medical Care Coordination Services Summary Information:

Does your clinic have MCC services? ☐ Yes ☐ No

Has client ever been assessed by MCC team? ☐ Yes ☐ No **Assessment Date:** _____

Most Recent Acuity Level: ☐ Severe ☐ High ☐ Moderate ☐ Self-Managed

Patient Issues: ☐ Mental Health ☐ Chronic Homelessness ☐ Substance Abuse
☐ Hostility ☐ History of Incarceration

Additional Notes: _____

_____

Has the client been discharged from your clinic? ☐ Yes ☐ No
If yes, why? _____

DHSP – OFFICE USE ONLY

DHSP staff must verify that client received services at the referring clinic within the last 12-24 months
Accept Referral for LRP Program assignment? ☐ Yes ☐ No **Casewatch/Client ID #:** _____

If no, comment:
☐ Deceased ☐ In Care Elsewhere
☐ Out of LA County ☐ Due Diligence not completed by provider