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Community HIV Support Worker Referral Form

*Community agency to contact referring source with name of assigned HIV Support Worker within 2 business days of referral.

Client Information		**Referral Date:** (dd/mm/yy)
Last Name:	**First Name:** **Preferred Name:**	**PHN #:**
Gender Identity:	**Date of Birth:** (dd/mmm/yyyy)	**Client identifies with an indigenous ethnicity:** ❒ yes ❒ no
Client Phone #	**Alternate Contacts/email:**	**Preferred Language:**
Current Address and Contact Details:		**Hangout Spots:**

Referral Source Details	**Client Aware of Referral?** ❒Y ❒N	
Organization Name	Contact Name	Contact Number/fax

Reason for Referral

❒ New Dx ❒ Collaboration to support adherence issues ❒ Social Supports (homelessness, food and income security, transportation, mental health, etc.) ❒ Transition from clinical team to community ❒ Other:

Client Status			**Additional Comments:**(inclusive of other health or safety concerns, provide details below)	
HIV Care Provider:		Date of last visit (dd/mm/yy)		
VL:		Date of last draw (dd/mm/yy)		
On ARVs? ❒ Yes ❒ No	**Adherence issues?** ❒ Yes ❒ No	Date started on ARV's (dd/mm/yy)	**On OAT?** ❒ N ❒ Y (if yes, name of med & dose)	**Pharmacy/Provider:**

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

Supports Requested:

Community HIV Support worker requested to provide updates to referring source:
❒ weekly ❒ bi-weekly ❒ monthly ❒ every 2 months ❒ every 3 months ❒ every 6 months ❒ no update required