Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
GYN Oncology	GYN Oncology	Symptoms / chief complaint Reason for referral Current medications / frequency / dose Pertinent H&P Interventions / results list any pre-existing conditions Additional Information: Gravida, Para, LC ? Smoker/Chew? ETOH?: None/past/current BMI (or current weight in lbs & kg + current height)	Labs* X-Ray* CD Disc of Radiology* CT Abd/Pel w/ contrast* Pelvic Ultrasound* Colonscopy* PAP* Biopsy* Pathology Report* Immunization History*
HIV/EIS	HIV EIS Consult	Description of problem Date of HIV diagnosis HIV status : HIV + asymptomatic? AIDS by CD4<200? AIDS by opportunistic infection? Unknown ? HIV + Date/reason for AIDS diagnosis Risk factors for HIV: Heterosexual? MSM? IVDU? Perinatal? Transfusion? Unknown? Brief History: include any opportunistic infections, co-morbid conditions, etc. Prenancy status / contraception Hepatitis status (Hep C chronic; Hep C resolved; Hep B carrier; Hep B immune) Current HIV meds/doses/start date and prophylactic meds Adherence issues Other meds/doses List any HIV medications EVER taken Immunization History (dates of administration/immunity) Previous HIV history and pertinent medical history from past providers (include name and contact info for NOTE: If you feel that an HIV case requires urgent attention or a reply to a sent case has not been	CD4 (last 3) Viral load (last 3) Genotype (attach/list all previous and current resistance mutations) Phenotype Tropism CBC* CMP* Urinalysis* Renal function panel* Lipid Panel* STD screen (oral, rectal, urine)* RPR* CMV AB IGG* Toxoplasma AB IGG* Chronic Hep (A,B,C) screen HBVsAB* HLA B-5701* Cervical PAP* Anal PAP* TB Screening* Dental Screening* Ophtho screening (dilated)* Mental Health Screening* Substance abuse screening*