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

| Service | Form name | Information Provider needs to fill in | Documentation/Labs/PreWork/Etc (* if optional) |
|---|---|---|---|
| HIV/EIS | HIV EIS Referral | Description of problem<br><br>Date of HIV diagnosis<br>HIV status (HIV + asymptomatic; AIDS by CD4<200; AIDS by opportunistic infection; unknown)<br>Reporting to State (Unknown, HIV reported to State Epi; AIDS reported to State Epi)<br>Brief History: include any opportunistic infections, co-morbid conditions, etc.<br>Current HIV meds/doses/start date and prophylactic meds<br><br>Other meds/doses<br><br>List any HIV medications EVER taken | CD4*<br><br>Viral load*<br><br>Genotype (attach all)*<br><br>Other (if done)* |
| Internal Med | Back/Neck Pain Referral Request | Has this patient had prior back/neck surgery<br>Prior Epidural Steroid Injections (ESI)? How many times? Beneficial?<br>Conservative treatments tried: PT? Medications? Accupuncture? Massage? Chiropractic Care? Other?<br>Neurological Symptoms: Numbness? Tingling? Weakness? Pain? Other? Location of neurological<br>MRI of affected area? Date of most recent.<br>Patient claustrophobic? If yes, anti-anxiety medication must be prescribed by primary care provider.<br>Any metal in body/worked with metal/gotten metal in eye?<br>Patient over 350 pounds? | |
| Internal Med | E-Consultation | Specialty Clinic requested: Diabetic; Dermatology; Endocrinology; General Int Med; Nephrology;<br><br>Symptoms / chief complaint<br><br>Reason for referral<br><br>Current Meds: Frequency AND dose<br><br>Pertinent H&P<br><br>Interventions / results<br>Does patient need escort? Does patient use Oxygen at home? If yes, attach escort request form | Supporting Studies done and date provided: labs, Xrays, CT, MRI, Ultrasound |