

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