



The Ryan White Program
Infectious Disease Referral Form

Patient Information:

Today's Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

Address: _____

Phone: ___-___-___ SSN: ___-___-___ Email: _____

Referral Method: _____ Referral Phone: ___-___-___

HIV Dx: ___/___/___ CD4: _____ VL: _____ Last Labs: ___/___/___

HIV Med(s): _____ Supply # _____

Medical History:

Employment & Insurance Information:

Employed Unemployed SSI/SSDI Other: _____

Insurance?: Yes No Insurance Company: _____ Rx Coverage?: Yes No

ADAP: Will Apply at Intake Application Completed Already Enrolled Not Needed

--RW Staff Use Only--

Assignments:

Athena #: _____ PE #: _____ NE: _____ MCM: _____

Intake: Date: ___/___/___ Time: _____ Missed Intake Appointment

Follow-up Notes: _____

