Project New Hope/Homestead Division
HIV/AIDS Diagnosis Form

Date: ____________________ Patient's Name: ____________________________________ Date of Birth: ________________

Social Security Number: ____________________________ **SEX:** Male Female Other

RACE/ETHNICITY: White Black Hispanic Other

ETIOLOGY: Homosexual Bisexual Hemophiliac IV Drug Abuse Blood Transfusion
Heterosexual

DIAGNOSIS: HIV Asymptomatic HIV Symptomatic Date: ______ AIDS Symptomatic Date: _______

Symptoms Include: ____

Opportunistic Infections (give dates)

CD4 _______
KS _______
PCP _______
Other _______

Has patient been screened for TB? Yes No
TB Skin Test Date: Positive Negative
TB Chest X-ray Date: Positive Negative

Is Patient currently receiving preventive TB Treatment? Yes No
Is Patient receiving treatment for Active TB? Yes No

Karnofsky Scale Assessment:

Stage	Range	Score	Description
Stage I:	71-100	100	Normal, no complaints, no evidence of disease
		90	Able to carry on normal activity, minor signs or symptoms of disease
		80	Normal activity with effort, some signs or symptoms of disease
Stage II:	51-70	70	Cares for self. Unable to carry on normal activity or do active work
		60	Able to care for most needs; requires occasional assistance
Stage III:	31-50	50	Requires considerable assistance and frequent medical care
		40	Disabled, requires special care and assistance
Stage IV:	10-30	30	Severely disabled, hospitalization is indicated. death not imminent
		20	Very ill; active supportive treatment
		10	Moribund, fatal processes progressing rapidly

What is the client's actual Karnofsky Score? _________

Does the client meet Nursing Facility Level of Care? Yes No

Observation on an ongoing intermittent basis and 24hr supervision to meet his or her health needs
Required professional nurse observation for response and effect on an intermittent basis
Need encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence

Vision, hearing or sensory loss
Limitation in movement
Incontinent of urine and/or bowels
Mild confusion or depression
Requires assistance or supervision in personal care

I certify that I am the personal physician of (client's name): ________________________________

Physician Signature: ________________________________ Date: ________________

Physician Name (Please Print): ________________________ **License #:** ______________

Address: ____ Phone: ________________

LOS ANGELES COUNTY TUBERCULOSIS CONTROL PROGRAM
TUBERCULOSIS SCREENING FORM
FOR RESIDENTIAL HOSPICES, SHELTERS & DAY CARE FACILITIES

Patient: ______________________________

Physician: ______________________________ Referral Source: ________________

Diagnosis - TB Disease: ______ TB Suspect: ______ Mantoux Reactor Only: ______

None of the Above: ______

REQUIRED TB SCREENING:

CHEST X-RAY: (Must Be Within 4 Weeks) Date: __________ Normal: _____ Abnormal: _____

CXR READING: ____

BACTERIOLOGY FOR AFB:
[Suspects and known Pulmonary TB cases must have 3 negative Sputum Smears before placement]

Date	Specimen	Smear Concentrate	Culture	Pending
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

ANTI-TUBERCULOSIS MEDICATION:

	Dose	Date Started
Isoniazid:	______	________
Rifampin:	______	________
Pyrazinamide:	______	________
Ethambutol:	______	________
________	______	________

RECOMMENDED TB SCREENING:

MANTOUX (PPD): * Date: __________

Reading: ________mm

Positive by History: ______

Anergic: ______

Not Done: ______

Based on the above information, I certify that this patient does not have communicable/infectious tuberculosis.

Signature: ____________________M.D. Date: ____________ Phone: ____________

* Isoniazid (INH) preventive therapy is indicated for all HIV infected Mantoux reactors and should be considere for anergic persons from groups in which the prevalence of tuberculosis infection is high, such as contacts c known cases of pulmonary TB, IDU's, prisoners, homeless persons, migrant laborers, and persons born in countries in Asia, Africa and Latin America with high rates of tuberculosis.

[For Consultation, Call L.A. County TB Control @ 213-744-6151]