HIV Transfer of Care Report Form

Mail completed form to:

Rhode Island Department of Health, Center for HIV, Hepatitis, STDs, and TB Epidemiology

3 Capitol Hill, Room 106, Providence, RI 02908

Phone: 401-222-2577, Fax: 401-222-6001

Reporting Facility/Provider

Date Form Completed:	**Person Completing Form:**	
Facility Name:	**Provider Name:**	**Phone:**

Patient Information

Last Name:	**First Name:**	**Middle Name:**
Alias:	**DOB:**	**SSN:**
Street Address:	**Apt #:**	**City:**
County:	**State/Country:**	**Zip Code:**
Phone:	**Alternate Contact:**	

Sex at Birth: ☐ Male ☐ Female ☐ Unknown **Birth Country:**

Current Gender Identity: ☐ Male ☐ Female ☐ Unknown ☐ Transgender FTM ☐Transgender MTF ☐ Other (Specify) _____ ☐ Transgender Unspecified

Race: ☐American Indian/AK Native ☐ Asian ☐ Black/ African American ☐ Native HI/ Pacific Islander ☐ White ☐ Don't Know

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐ Don't Know

Reported Risk:

☐ Sex w/ male
☐ Sex w/ female
☐ Injected non-prescription drugs (IDU)

Heterosexual contact w/:

☐ Injection drug user
☐ Bisexual male
☐ Person with hemophilia/coagulation disorder
☐ Transfusion recipient with documented HIV infection
☐ Person with documented HIV infection

☐ Other documented risk
☐ Worked in a health care or clinical laboratory setting
☐ No identified risk factor (NIR)

Received:

☐ Clotting factor for hemophilia/coagulation
☐ Transfusion of blood/blood components (other than clotting factor)
☐ Transplant of tissue/organs or artificial insemination

Transfer of Care Information

*If known, please provide information on the provider, facility, or state providing care **prior** to transfer to **your** facility*

Previous Facility Name:	**Previous Facility Address:**

Patient's Residence Prior to Transfer:
If exact address is unknown, please provide patient's state/country of residence prior to transfer

Diagnosing Information

Date of Diagnosis: *If exact date is unknown, please provide an approximate*	**Patient Residence at Diagnosis:** *If exact address is unknown, please provide patient's state/country of residence at the time of diagnosis*

Has the patient ever experienced an AIDS defining opportunistic infection or had a CD4 < 200? ☐ Yes ☐ No ☐ Unknown

OI: _____ **Date:** _____/_____/_____ **CD4:** _____ **Date:** _____/_____/_____