

HIV Client Services Request HIV Medication Adherence Aids



Instructions:

- **Complete one request per client.**
- **Do NOT enter this adherence aid in CAREWare. However, you should enter your time associated with facilitating the receipt of this item.**

1. Date of Request: _____

2. Client eURN # (encrypted unique record number from CAREWare client record): _____

3. Requested For:

1 Adherence Watch (please choose one): Men's Women's

1 Medication Box

4. Please describe how this request will assist your client in managing their HIV Medications:

5. I have referred to the Ryan White Title II Case Management Standards of Service and have reviewed and updated the clients Drug Adherence Assessment form (which is included in the client chart). Based on this assessment, I have determined that this individual would benefit from the requested adherence aid. In addition, I have discussed this resource with the client and they are willing to use the device for its intended adherence purposes.

HIV Case Manager Name: _____

Address: _____

Phone: _____

Email: _____

Signature: _____

Date: _____

**IMMEDIATELY FAX THIS REQUEST TO DHS, HEALTH SERVICES- HIV CLIENT SERVICES AT
503-731-4057, ATTENTION: THIRD PARTY ADMINISTRATOR**