**Medical Assessment**

"Confidential ⎯ this form must always be saved on a secure network
accessible only by Ryan White funded staff."

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client name: |       | Client number: |       | DOB: |       | Date: |    /    /      |

### CM initial:       [ ]  Initial assessment [ ]  Reassessment

### Current Psychosocial Acuity *(regional only)*:       Date:   /  /

### Vitals

Phone Assessment Completed [ ]

Comments:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Temp:**  |       | **Pulse:**  |       | **Respiration:** |       | **B/P:** |       |
| **Height:** |       | **Current weight:** |       | **BMI:** |       |  |  |

### Labs and Medical provider

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Current: VL** | **Date** |  | **Lowest: VL**  | **Date** |  | **Highest: VL**  | **Date** |
|       |    /    /      |  |       |    /    /      |  |       |    /    /      |
| Virally suppressed? | [ ]  Yes [ ]  No |  | Virally suppressed? | [ ]  Yes [ ]  No |  | Virally suppressed? | [ ]  Yes [ ]  No |
|  |  |  |  |  |  |  |  |
| **Current: CD4 Count** | **%** |  | **Lowest: CD4 Count** | **%** |  | **Highest: CD4 Count** | **%** |
|       |       |  |       |       |  |       |       |
| **Date** |    /    /      |  | **Date** |    /    /      |  | **Date** |    /    /      |
|  |  |  |  |  |  |  |  |
| **Last medical visit:** |    /    /      | Provider name:      | Provider type:       |
| **Referred to** **medical provider** |    /    /      | Provider name:       | Provider type:       |
| Comments:       |

|  |  |
| --- | --- |
| **HIV status** | **HIV risk factors *(check all that apply)*** |
| [ ]  HIV positive *(not AIDS)* | dx date: |    /    /      | [ ]  MSM [ ]  Heterosexual [ ]  IDU [ ]  Perinatal |
| [ ]  HIV positive *(AIDS unknown)* | dx date: |    /    /      | [ ]  Receipt of blood or tissue |
| [ ]  CDC – defined AIDS | dx date: |    /    /      | [ ]  Hemophilic coagulation disorder |
| [ ]  HIV indeterminate (*infants <2*)  | dx date: |    /    /      | [ ]  Unknown or not reported/identified |
|  |  |  | [ ]  Other: |       |

### Physical appearance

Phone Assessment Completed [ ]

Comments:

|  |  |
| --- | --- |
| Physical deformities |       |
| Posture/mobility |       |
| Skin |       |
| Demeanor |       |
| Speech/hearing |       |
| Personal hygiene |        |
| Comments:       |

### Allergies

|  |  |
| --- | --- |
| Medications: [ ]  Yes [ ]  No | List:       |
| Food: [ ]  Yes [ ]  No | List:       |
| Environmental: [ ]  Yes [ ]  No | List:       |

**Activities of daily living *(self, assistance needed or dependent)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Self** | **Asst.** | **Dep.** | **Activity** | **Self** | **Asst.** | **Dep.** |
| Ambulation | [ ]  | [ ]  | [ ]  | Housekeeping/laundry | [ ]  | [ ]  | [ ]  |
| Transfers/toileting | [ ]  | [ ]  | [ ]  | Shopping/meal prep/eating | [ ]  | [ ]  | [ ]  |
| Bathing/grooming/dressing | [ ]  | [ ]  | [ ]  | Driving/getting to appointments | [ ]  | [ ]  | [ ]  |
| Comments:       |
| Pets/companion animal: [ ]  Yes [ ]  No | Type:       |

### Current complaints

| **X = Yes** | **Description** | **X = Yes** | **Description** | **X = Yes** | **Description** |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Abdominal pain | [ ]  | Genital discharge/odor | [ ]  | Falls |
| [ ]  | Changes in eating habits | [ ]  | Fever | [ ]  | Changes in strength |
| [ ]  | Nausea/vomiting | [ ]  | Chills | [ ]  | Numbness |
| [ ]   | Diarrhea | [ ]  | Fatigue | [ ]  | Pain |
| [ ]  | Unexplained weight loss | [ ]  | Night sweats | [ ]  | Chest pain |
| [ ]  | Difficulty swallowing | [ ]  | Swollen lymph glands | [ ]  | Cough |
| [ ]  | Sores in throat or mouth | [ ]  | Seizures/tremors | [ ]  | Shortness of breath |
| [ ]  | Changes in hearing | [ ]  | Dizziness | [ ]  | Skin changes/rashes |
| [ ]  | Changes in vision | [ ]  | Changes in balance | [ ]  | Edema |
| [ ]  | Genital sores/oral lesions | [ ]  | Headaches *(changes in pattern)* | [ ]  | Changes in sleep |
| [ ]  | Pain/burning with urination | [ ]  | Jaundice/Icterus | [ ]  | Other:       |
| [ ]  | Pain with sex | [ ]  | Menstrual changes |  |  |
| [ ]  | Genital itching | [ ]  | Gum bleeding |  |  |
| Comments:       |

### Medical history

Has client ever been diagnosed with the following infections or conditions? *(C=current; P=past)* [ ]  None

|  |  |
| --- | --- |
| HIV Related Conditions/Opportunistic Infections | Other Comorbidities |
| [ ]  C [ ]  P | ACD *(AIDS Dementia complex)* | Head/Sensory/Neuro | Endocrine |
| [ ]  C [ ]  P | Candidiasis | [ ]  C [ ]  P | Ear, nose and throat | [ ]  C [ ]  P | Diabetes |
| [ ]  C [ ]  P | Cervical cancer | [ ]  C [ ]  P | Hearing problems | [ ]  C [ ]  P | Thyroid problems |
| [ ]  C [ ]  P | Coccidioidomycosis | [ ]  C [ ]  P | Vision problems | Musculoskeletal |
| [ ]  C [ ]  P | Cryptococcal meningitis | [ ]  C [ ]  P | Epilepsy | [ ]  C [ ]  P | Arthritis |
| [ ]  C [ ]  P | Cryptosporidiosis | [ ]  C [ ]  P | Headaches/migraines | [ ]  C [ ]  P | Osteoporosis |
| [ ]  C [ ]  P | CMV *(Cytomegalovirus)* | [ ]  C [ ]  P | Neurocognitive disorders | [ ]  C [ ]  P | Myopathy |
| [ ]  C [ ]  P | Encephalopathy | Pulmonary | [ ]  C [ ]  P | Neuropathy |
| [ ]  C [ ]  P | Herpes zoster *(Shingles)* | [ ]  C [ ]  P | Asthma | [ ]  C [ ]  P | Musculoskeletal problems/injuries |
| [ ]  C [ ]  P | Herpes simplex | [ ]  C [ ]  P | COPD | Other |
| [ ]  C [ ]  P | Histoplasmosis | [ ]  C [ ]  P | Chronic/recurrent sinusitis | [ ]  C [ ]  P | Kidney problems |
| [ ]  C [ ]  P | Isoporiasis | Cardiovascular | [ ]  C [ ]  P | STI *(sexually transmitted infection)* |
| [ ]  C [ ]  P | Kaposi’s sarcoma | [ ]  C [ ]  P | High blood pressure | [ ]  C [ ]  P | Cancers |
| [ ]  C [ ]  P | Leukeoncephalopathy | [ ]  C [ ]  P | Blood clots | [ ]  C [ ]  P | GI problems |
| [ ]  C [ ]  P | Lymphoma | [ ]  C [ ]  P | Myocardial infarction | [ ]  C [ ]  P | Skin problems |
| [ ]  C [ ]  P | Mycobacterium *(MAC, etc.)* | [ ]  C [ ]  P | Cholesterol — elevated | [ ]  C [ ]  P | Mental Health Diagnosis (*anxiety, depression, PTSD, bipolar, etc.)* |
| [ ]  C [ ]  P | PCP *(Pneumocystis carinii pneumonia)* | [ ]  C [ ]  P | Thrombocytopenia |
| [ ]  C [ ]  P | Pneumonia | [ ]  C [ ]  P | Stroke | [ ]  C [ ]  P | Substance Use Disorders |
| [ ]  C [ ]  P | PML *(Progressive multifocal leukoencephalopathy)* | [ ]  C [ ]  P | Heart Disease | [ ]  C [ ]  P | Sleep problems |
| [ ]  C [ ]  P | Samonella septicemia | [ ]  C [ ]  P | Other:       | [ ]  C [ ]  P | Other:       |
| [ ]  C [ ]  P | Toxoplasmosis | Liver |
| [ ]  C [ ]  P | Tuberculosis | [ ]  C [ ]  P | Cirrhosis |
| [ ]  C [ ]  P | Wasting Syndrome | [ ]  C [ ]  P | Hepatitis A, B or C |
| [ ]  C [ ]  P | Other:       | [ ]  C [ ]  P | Liver disease/abnormal LFTS |
| Hospitalizations*(for physical or behavioral conditions)*:       |
| Surgeries:       |
| Comments*(treatment plans, etc)*:       |

### Reproductive health

|  |
| --- |
| ***(X-Yes)***[ ]  Pregnant [ ]  Birth control type:      [ ]  Breast-feeding [ ]  Seeking pregnancy[ ]  Erectile dysfunction [ ]  Cancer *(cervical, ovarian, prostate, testicular, anal)* [ ]  Other:        |
| Comments:       |

### Immunizations & Screenings

|  |  |
| --- | --- |
| **Current on immunizations: *(X-Yes)***[ ]  Flu (*annual*)[ ]  Hepatitis A[ ]  Hepatitis B[ ]  HPV[ ]  Meningococcal[ ]  MMR[ ]  Pneumonia[ ]  Shingles[ ]  Td/Tdap[ ]  Varicella[ ]  Mpox[ ]  COVID-19 | **Current on screenings: *(X-Yes)***[ ]  Breast exam/mammogram[ ]  Cholesterol[ ]  Colonoscopy *(over 50)*[ ]  Gonorrhea [ ]  PAP[ ]  Prostate[ ]  Syphilis[ ]  TB[ ]  Other       |
| Comments:       |

### Tobacco

|  |  |
| --- | --- |
| **Tobacco use:**[ ]  Ceremonial or medicinal purposes [ ]  Never [ ]  Past[ ]  Present: [ ]  Cigarettes [ ]  Chew [ ]  Cigars [ ]  Vaporizer Amount:      [ ]  Interested in cessation |  |
| Comments:       |

**Medications & adherence**

Please ensure all medications, including supplements and vitamins, are listed on medication profile.

|  |  |
| --- | --- |
| Currently prescribed ARVs?[ ]  Yes[ ]  NoIf no, why not?[ ]  Not clinically indicated[ ]  Does not want to take[ ]  Considering [ ]  Has not seen Dr. yet[ ]  Other       | Currently prescribed other medications?[ ]  Yes[ ]  No |
| Currently taking OTCs, supplements, vitamins or alternative/complementary medicine?[ ]  Yes[ ]  No[ ]  Other       |
| Currently taking illegal drugs or prescription medications that have not been prescribed?[ ]  Yes[ ]  No |
| Are ARVs taken as prescribed?[ ]  Yes[ ]  Sometimes[ ]  No | Are other medications taken as prescribed?[ ]  Yes[ ]  Sometimes[ ]  No |
| **If yes/sometimes:**Who is responsible for refilling medications?      Picking up meds:      Giving meds:       | **If no/sometimes:**Medications missed: [ ]  ARVs [ ]  Mental Health [ ]  OtherNumber of missed doses in past month:      Number of late doses in past month:      Reasons for missed/late doses:       |
| **Are medications: *(X-Yes)***[ ]  Borrowed from others[ ]  Outdated[ ]  Prescribed by multiple providers[ ]  Properly stored | **Side effects: *(X-Yes)***[ ]  Diarrhea[ ]  Dizziness[ ]  Drowsiness[ ]  Headache[ ]  Nausea/vomiting[ ]  Other:       |
| **Barriers to adherence: *(X-Yes)*** |
| **Beliefs**[ ]  Lack of information[ ]  Doubts effectiveness[ ]  Religious/spiritual[ ]  Other:       | **Life situation**[ ]  Lack of regular schedule[ ]  Work outside home[ ]  Caregiving responsibilities[ ]  Unstably housed | **Logistics**[ ]  Needs help with ADLs[ ]  Difficulty getting refills[ ]  Insurance problems[ ]  Access to medical supplies *(e.g.syringes)* | **Mental/emotional**[ ]  Depression[ ]  Unstable mental health[ ]  Cognitive changes[ ]  Developmental disabilities |
| **Physical**[ ]  Loss of appetite[ ]  Fatigue[ ]  Side effects[ ]  Comorbidities | **Regimen**[ ]  Complexity[ ]  Number of pills[ ]  Size of pills[ ]  Taste of pills | **Social**[ ]  Lack of support system[ ]  Undisclosed HIV status | **Other:**       |
| Comments:       |

**Nutrition**

|  |  |
| --- | --- |
| **Visual assessment: *(X-Yes)***[ ]  Underweight[ ]  Overweight[ ]  Obese[ ]  Lipodystrophy[ ]  Wasting syndrome[ ]  Other:       | **Barriers: *(X-Yes)***[ ]  Access to food[ ]  Type of food available[ ]  Loss of appetite[ ]  Hyperlipidemia[ ]  Lack of cooking experience[ ]  Recent changes in eating habits[ ]  Problems eating *(chewing/swallowing)*[ ]  Abdominal issues *(pain, diarrhea, nausea/vomiting)*[ ]  Diabetes[ ]  HTN[ ]  Food allergies/sensitivities[ ]  Eating disorders *(anorexia, binging, bulimia)*[ ]  Dental issues[ ]  Exercise[ ]  Other:       |
| Comments:       |

**Oral Health**

|  |  |
| --- | --- |
| **Last dental visit:**       | **Current hygiene practices:**       |
| **Exam: *(X-Yes)***[ ]  Missing teeth[ ]  Dark, discolored or decayed teeth[ ]  Bleeding gums[ ]  White hairy growth[ ]  Creamy, bump-like patches[ ]  Oral lesions[ ]  Pain/sensitivity[ ]  Difficulty eating or speaking[ ]  Dentures and/or need re-alignment[ ]  Other:       | **Barriers to oral health: *(X-Yes)***[ ]  Lack of insurance[ ]  Lack of dentist[ ]  Lack of transport[ ]  Fear of dentist[ ]  Other:       |
| Comments:       |

**Interventions & Referrals**

|  |  |  |
| --- | --- | --- |
| **Nursing area** | **Referrals & Interventions Provided** | **Comments** |
| Medical | [ ]  Disease education and information[ ]  OTC, vitamins, supplements[ ]  Mental Health treatment[ ]  Substance use treatment[ ]  Naloxone[ ]  Aging & Persons with Disabilities[ ]  Health insurance assistance[ ]  Referral to acupuncture[ ]  Referral to PCP[ ]  Referral to HIV specialist[ ]  Referral to other specialist[ ]  Referral to Aiquitline/Quitline/NRT[ ]  Other:       |       |
| Adherence | [ ]  Pill boxes/reminders[ ]  [ ]  Referral to pharmacist[ ]  Other:       |       |
| Nutrition | [ ]  Nutritional supplements [ ]  Nutritional incentive contract[ ]  Referral to food banks/soup kitchens[ ]  Referral to dietician[ ]  Online resources *(meal ideas)*[ ]  Cooking classes[ ]  Exercise plan[ ]  Dietary changes[ ]  Other:       |       |
| Oral Health | [ ]  Oral health care education[ ]  Dental insurance[ ]  Referral to dentist[ ]  Other:       |       |
| Other | [ ]  Mindfulness/self-help [ ]  Other:       |       |
| **Staff name and credentials:** |  | **Date:** |    /    /       |