Interior Health

REFERRAL

Health Outreach Team
1-866-778-7736
Fax 250-549-6310

Referral Date *(yyyy/mm/dd)*		**Is Client aware of referral?** ☐ Yes ☐ No	
Last Name	First Name		PHN
Gender	Date of Birth *(yyyy/mm/dd)*	Ethnicity	Language Details
Permanent Address ☐ Unknown		Phone	
Current Location and Contact Details ☐ Unknown			

Referral Source Details	
Contact Name	Affliliated organization / clinic

Reason for Referral

☐ **Testing / Screening**
☐ **Newly diagnosed HIV+** (from HIVSS)
☐ **Known HIV+** Re-Engage client (Lost to Care)
☐ **Known HIV+** Strengthen client engagement in care

Client Status	**Date** *(yyyy/mm/dd)*	**Comment**
Primary Care Provider	*(Date of last visit)*	
CD # 4 and % *(if known)*		
pVL # *(if known)*		
On ARVs? ☐ Yes ☐ No ☐ Unknown		
Adherence issues? ☐ Yes ☐ No ☐ Unknown		

Social & Community Supports *(Name / Organization)*	**Nature of Involvment / Support**	**Contact Number**

Additional Details / Services Requested