 

**UF CARES/River Region PATH Home Project**

**Partnership for Access to Treatment and Housing (PATH HOME) HIV/Homeless SPNS**

**Screening Referral Form**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last known location of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes or No

1. Is this client HIV Positive? Diagnosis date \_\_\_\_\_\_\_\_\_\_\_ ⃝ ⃝
2. Is this client lost to care 6 months or more? ⃝ ⃝
3. Is this client pregnant? ⃝ ⃝
4. Is this client homeless? ⃝ ⃝

If yes, since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this client have unstable housing? ⃝ ⃝

If yes, since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this client been released from prison/jail in the past 6 mths? ⃝ ⃝
2. Has this client been released from the hospital in the past 3 mths? ⃝ ⃝
3. Does the client have a substance abuse history? ⃝ ⃝

If yes, drug of choice & last use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this client have a Mental Health history? ⃝ ⃝

Diagnosis and when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please assess the following:

1. Is client able to verbally describe the purpose of the study? ⃝ ⃝
2. Is client able to verbally describe risks and benefits? ⃝ ⃝
3. Is client able to verbalize understanding that they would

not lose services whether or not they participated? ⃝ ⃝

1. Is client able to verbalize understanding of his/her rights

to withdrawal consent and terminate participation? ⃝ ⃝

1. Is client able to verbalize right to refuse to answer questions? ⃝ ⃝

If client is unable to accurately respond to above questions, the client should not be consented into the study until a referral and assessment is made by the psychologist to determine capacity to participate in the study. **STOP**

1. Is the client on any current medications? ⃝ ⃝

If yes, medication names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this client ever been diagnosed with AIDS? ⃝ ⃝

If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax completed referral to: [Staff Name] @ 904-XXX-XXXX

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>