Réseau ACCESS Network HIV/Hepatitis Health and Social Services | Services sociaux et de santé pour l'hépatite et vih

APPLY PATIENT LABEL

TAP CLINIC REFERRAL

FAX 705-222-5276

Patient information

Preferred name		**Primary care provider**	
Pronouns		**Insurance type**	☐OHIP ☐UHIP ☐ IFH ☐Other/Unknown
Primary language		**Drug coverage**	☐Private ☐ODB ☐ None ☐Other/Unknown

Reason for referral

☐ **HIV treatment**	☐ **HIV pre-exposure prophylaxis (PrEP)**	☐ **Doxycycline PEP**
Date of diagnosis:	Has the patient ever used HIV PrEP or PEP?	Has the patient ever used HIV PrEP or PEP?
	☐Yes ☐No ☐ Unknown	☐Yes ☐No ☐ Unknown
Is patient aware of diagnosis?	If yes, medication used:	Date of last bacterial STI diagnosis:
☐Yes ☐No ☐ Unknown		

Allergies (list):

☐ **Please attach a list of current medications** (prescribed, over-the-counter, vitamins, minerals, herbal supplements) and **any past HIV medications (treatment, PrEP, or PEP)**

Past medical history

☐ HAV infection	☐ Hypertension	☐ Syphilis infection
☐ HAB infection	☐ Dyslipidemia	☐ Gonorrhea infection
☐ HCV infection – Treated & cleared	☐ Substance use	☐ Chlamydia infection
☐ HCV infection – Chronic / untreated	☐ Osteoporosis	☐ Other:
☐ HCV infection – Treatment ongoing	☐ Chronic kidney disease	☐ Other:
☐ Cardiovascular disease	☐ Depression	☐ Other:
☐ Diabetes (circle: 1 OR 2)	☐ Anxiety	☐ Other:

For patients referred for HIV care, please attach the following if available

☐ HIV diagnostic serology	☐ Anti-toxoplasma IgG	☐ HAV testing
☐ HIV viral load (current, and at dx)	☐ HbA1c	☐ HBV testing
☐ CD4 count (current, nadir, at dx)	☐ Glucose (random)	☐ HCV testing
☐ HIV genotyping	☐ Creatinine (eGFR)	☐ Syphilis serology
☐ G6PD deficiency screening	☐ ALT, AST, and bilirubin	☐ Gonorrhea testing
☐ Vaccine records	☐ Urinalysis	☐ Chlamydia testing
☐ Tuberculin skin test results	☐ Lipid assessment	☐ Other:

Referring clinician

Name		**Billing number**	
Date		**Phone**	
Signature		**Fax**	