Sunshine FAMILY CARE

Patient Name: _____

Intake Form

Date of initial contact/referral: _____ ☐New Patient/Client ☐Reopen ☐Update

Referral Source: _____

Contact Information:

Date of Birth: Click or tap to enter a date.Social Security number: _____

Name: _____
Last First Middle Initial

Home address: _____
City Zip County

Mailing address (if different from home address) _____
City Zip County

Phone: Home _____ Other _____ (cell, work, other)

Primary Language: _____ Other language spoken or understood: _____

Do you need assistance with either of the following? ☐ Reading ☐ Writing ☐ NA

OK to send mail? ☐ Yes ☐ No If yes, plain envelope ☐ Yes ☐ No
OK to email? ☐ Yes ☐ No Email address: _____
OK to call? ☐ Yes ☐ No OK to leave a message? ☐ Yes ☐ No

Emergency Contact:

Name: _____

Address: _____

Relationship: _____

Phone: Home _____ Other _____

(If discretion is necessary, please put a "D" at the end of the number)

Sunshine FAMILY CARE

Patient Name: _____

RSR REQUIRMENTS

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Unknown

Race (Check all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ Unknown/not reported
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ Other _____

Ethnicity (if applicable, check in addition to race)

☐ Hispanic/Latino Type ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban
☐ Arab or Chaldean ☐ Another Hispanic, Latino or Spanish Origin
☐ African born

Self-Reported HIV Status ☐ Non Applicable (move to next question)

☐ HIV+ (non-AIDS) ☐ HIV Negative ☐ HIV+ (AIDS status not known)
☐ Infant/Indeterminate ☐ CDC defined AIDS

Date of Positive test: _____ ☐ Estimated AIDS Date: _____ ☐ Estimated

Primary risk factors *(Check all that apply)*

☐ Men who have sex with men (MSM)
☐ Hemophilia/coagulation blood disorder
☐ Receipt of blood, blood components, or tissue
☐ Undetermined/unknown/risk not identified or reported
☐ Injection drug user (IDU)
☐ Heterosexual contact
☐ Perinatal transmission

Source of medical insurance:

☐ No health insurance ☐ Medicaid ☐ Medicare
☐ Private insurance: Company name _____
☐ Other public insurance Name: _____
☐ Other insurance Name: _____ ☐ Unknown/not reported

Primary Source of Medical Care:

☐ No primary source of medical care
☐ Publicly funded clinic or health department
☐ Hospital outpatient center
☐ Unknown/not reported
☐ Private practice
☐ Emergency Room
☐ Other _____

Housing status

☐ Permanently Housed ☐ Non-permanently Housed (includes homeless)
☐ Institution ☐ Other _____ ☐ Unknown/unreported

Household size: _____ (How many people live with you)

Financial Information

Gross Annual Household Income $_____

Gross Personal Income (amount you bring in/or you make) $_____

Work Status: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Disabled ☐ Sick leave
☐ other: _____

Other sources of income or benefits and amount: (Pensions, Child Support, Investments, Retirement Benefits, food stamps, parental support etc.) _____

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Patient Name: _____

Medical/Health

Primary Doctor:
Name or Facility Name _____ Phone _____
☐ Need a Primary Doctor Date last seen? _____

HIV Medical Provider if applicable:
Name or Facility Name _____ Phone _____
☐ Needs Infectious Disease Doctor Date last seen? _____

OB/GYN Doctor: Name _____ Phone _____
(If female)
☐ Needs OB/GYN Doctor Date last seen? _____

Other Medical Providers: _____

If Applicable:
Self- Reported CD4 count: _____ Date: _____
Self- Reported Viral Load: _____ Date: _____

Any Co-Infection/Other significant diagnosis (Please specify and dates) _____

_____

Mental Health

Have you ever been diagnosed with Depression/Anxiety/Bi-Polar/Schizophrenia/other mental health disorder?
☐ Yes ☐ No
Are you currently on medications for this? ☐ Yes ☐ No
List of Medications:

Name of Medication	Reason	Dosage	How Many Per Day
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Any Suicidal feelings? ☐ Yes ☐ No
If not current but in past When _____ Did you attempt suicide? ☐ Yes ☐ No

What did you do _____

Substances/Smoking 5A's

Alcohol/Drugs ☐ Yes ☐ No Type: _____ How often/How much _____
Do you use nicotine/E-Cig ☐ Yes ☐ No Type: _____
How much _____ Do you want to quit? ☐ Yes ☐ No

Sunshine FAMILY CARE

Patient Name: _____

Medication Status (If applicable, HIV Medication/Anti-retroviral Therapy)

- ☐ Never taken HIV medication
- ☐ currently taking HIV medication
- ☐ New to medication
- ☐ other _____

Immediate Health Care Needs:

- ☐ Emergency Treatment
- ☐ Urgent/ in crisis
- ☐ Infectious Disease Physician
- ☐ Primary Care Physician
- ☐ Medical Insurance
- ☐ Access to Medications

Other Presenting Problem(s):

- ☐ Housing
- ☐ Mental Health
- ☐ Transportation
- ☐ Substance use/abuse
- ☐ Food
- ☐ HIV Education
- ☐ Legal
- ☐ Social Support
- ☐ Homeless
- ☐ Other: _____

Signature of Patient or Advocate (If present for Intake): _____ Date: _____

Planned next appointment with patient (who): _____

Appointment Date _____ Time_____ Location: Sunshine Family Care
Meeting or appointment with: Doctor/ NP/ Case Manager

For Office Use Only

Intake Advocate Signature: _____ Date: _____

Summary of Services Needed:

- ☐ Referral for medical appointment with HIV specialist
- ☐ Referral for medical appointment with Primary Care
- ☐ Information and Referral only (NON-MEDICAL Case Management Services)
- ☐ Referral to Case Management (MEDICAL Case Management) (Assessment must be completed in 7 days)
- ☐ Reason(s) or/Need for Case Management Services: _____