**PACT is a program designed to assist people with managing their HIV and/or treating their Hepatitis C, address barriers to ART adherence, and improve utilization of medical and social resources.**

**Date of Referral** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Eligibility Information and Necessary Documentation:** Please check as appropriate |
| **Y** | **N** | **Criteria** |
| □ | □ | **Location –** *Resident of Dorchester, Roxbury, Mattapan, Jamaica Plain, Roslindale, Hyde Park, South End, Chelsea, Revere, Everett, East Boston, Charlestown, Cambridge, Allston, Somerville, and parts of Malden and Medford. Other neighborhoods will be considered based on proximity to enrolled PACT clients.* |
| □ | □ | **CD4** – CD4 count ≤500 cell/µl or CD4 Percent ≤18% (w/in the last 6 months)  |
| □ | □ | **HIV Viral Load** - ≥1000 copies/mL on at least two blood draws in the past year, including the latest blood draw within the last three months |
| □ | □ | **History of non-adherence to ART or challenges in engaging in care** |
| □ | **Current medication list:** Please attach current medicine list |
| □ | **Lab work attachment:** *Please attach copies of CD4, HIV viral load, and resistance genotyping done in the past 12 months. If lab results do not exist for the three months prior to referral, please repeat the tests for baseline purposes.* |

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| --- | --- | --- | --- |
| **1** | **Patient Information** | **2** | **Referrer Information** |
| **Name:****Email:**  | **Clinic/Hospital/Location:****Relationship to Client:** |
| **Address:** | **Referrer Name & Specialty:****Phone:****Email:** |
| **Phone:** | **Alternative Phone:** |

**How did you hear about PACT?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Referral** ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **3** | **Description of History of Medication/Care Adherence and Possible Barriers:** |
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| --- | --- |
| **4** | **Common concerns/behaviors that patients experience:** Explain all that apply. |
| Major co-morbidities and other chronic illnesses (end stage liver, heart, renal disease or PML, diabetes, hypertension, cancer, dementia, etc) |  |
| Psychiatric Diagnosis |  |
| Mental Health Symptoms |  |
| Cognitive Deficits |  |
| Substance Use |  |
| Domestic Violence |  |
| Housing Instability |  |
| Social Isolation |  |
| AIDS Defining Illness and AIDS Diagnosis Year |  |

|  |  |
| --- | --- |
| **5** | **Demographics:** |
| **DOB:** \_\_\_/\_\_\_/\_\_\_\_\_**SSN:** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**Country of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Race: | □ White□ Black/African American□ American Indian□ Other: | □ Asian□ Pacific Islander□ More than one raceLatino : □ Yes □ No |
|  **Gender:** □ Cisgender Male □ Cisgender Female □ Transgender □ Transman □ Transwoman □ Nonbinary □Other: |
| **Language:** □English □Spanish □ Haitian Creole □ Other : |
| **HIV Exposure Category:** □ Men who have sex with men □ Women who have sex with women □ Injection drug use □ Heterosexual contact □ Perinatal transmission □ Blood, blood products, or tissue □ Other: |
| **Insurance:****Policy #:** |

|  |  |
| --- | --- |
| **6** | **General Information:** |
| **Emergency Contact:****Emergency Contact Phone:****Disclosed to this person: Y / N**  |
| **HIV MD Name & Contact Information:** **Email:** |
| **PCP Name & Contact Information:****Email:** |

|  |  |
| --- | --- |
| **7** | **Other information:** |
| Other social issues relevant to health status and referral reason: |
| What is client’s support system? |
| Are there HIV disclosure issues? |