MANITOBA
HIV PROGRAM

Questions? Call the MB. HIV Program at
(204) 940-6089 or outside Wpg. 1-866-449-0165
Fax: (204) 940-6003

# *HIV PROGRAM REFERRAL FORM*

*** PATIENTS MUST BE INFORMED OF THEIR HIV TEST RESULT BY THE REFERRING PHYSICIAN**

Referral Date: _____

Patients name: _____ Date of Birth (mm/dd/yy) _____

Patients gender: ☐ Female ☐ Male ☐ Transgender _____

MHSC#: _____ PHIN: _____

Address: _____

**Patient's Preferred Method of Contact: (Please check phone numbers where we can leave a confidential message)**
***Please discuss with client the BEST way to reach them to discuss their HIV care:**

| | Method | Primary: Voicemail Y/N | Secondary: Voicemail Y/N |
|---|---|---|---|
| | **Phone #** | | |
| | **Email** | | |
| | **Mail** | | |

**Notes related to contacting client:**

| |
|---|
| |
| |

**Patients Preferred Language:** _____

**New HIV diagnosis:** ☐ **Yes** ☐ **No** ☐ **Unknown** Date of HIV Test: _____

*Please include past medical history (including labs, HIV antibody results and relevant labs)

**Acute Symptoms:**

| |
|---|
| |
| |

**Past Medical History:**

| |
|---|
| |
| |

**Future Care:** (There are options for HIV care; please check the option you and your patient would prefer)
**In Winnipeg, the client requires:**

☐ A family physician who will provide **both** primary care and HIV care at Nine Circles CHC

☐ An infectious disease specialist, who would provide HIV care **only** at Health Sciences Centre Ambulatory Clinic. Patient **must** have a Primary Care Provider (i.e., family physician, nurse practitioner).

Name of Provider that will be providing primary care: _____

Referring Provider: _____ Phone: _____ Fax: _____

**In Brandon and Surrounding area, the client requires:**

☐ A family physician who will provide **both** primary care and HIV care at 7th Street CHC

☐ A family physician who provides only HIV care at 7th St. Patient **must** have an alternative Primary Care provider in Brandon (i.e., family physician, nurse practitioner).

Name of Provider that will be providing primary care: _____

Referring Provider: _____ Phone: _____ Fax: _____