EARLY REFERRAL AND LINKAGE INITIATIVE
CASE MANAGER'S REFERRAL FORM

Instructions: Depending on the answer to each question below, it may be necessary to offer referral for testing or assessment. If the answer that you have checked is **BOLDED** then you should offer the referral suggested or another referral.

STD Needs:

1. Has client ever been tested for STDs?	Yes____	**NO**_____	**UNSURE**____
2. Was client ever diagnosed with an STD?	**YES**____	No_____	**UNSURE**____
3. If diagnosed, did client complete treatment?	Yes____	**NO**_____	**UNSURE**____
4. Were client's sexual partners also tested at that time?	Yes____	**NO**_____	**UNSURE**____
5. Did client's partners complete treatment?	Yes____	**NO**_____	**UNSURE**____
6. Does client currently have symptoms of any STD?	**YES**____	No_____	**UNSURE**____
7. If sexually active, has client been tested for STDs in the past 6 months?	Yes_____	**NO**_____	**UNSURE**____

(If referral is needed, offer referral for testing)

TB Needs:

1. Has client ever been tested for TB?	**YES**_____	No_____	**UNSURE**____
2. Has client ever been told they have TB?	**YES**_____	No_____	**UNSURE**____
3. Has client ever been treated for TB?	**YES**_____	No_____	**UNSURE**____
4. Does client have a cough that brings up mucous?	**YES**_____	No_____	**UNSURE**____
5. Does client have significant weight loss or night sweats?	**YES**_____	No_____	**UNSURE**____

(If referral is needed, offer referral to medical provider for assessment)

Risk Reduction Needs:

1. Does client have a risk reduction plan?	Yes_____	**NO**_____	Unsure_____
2. If "yes" is it working satisfactorily?	Yes_____	**NO**_____	Unsure_____
3. Is client engaging in unprotected sex?	**YES**_____	No_____	Unsure_____
4. Is client sharing uncleaned needles?	**YES**_____	No_____	Unsure_____

(If referral is needed, offer referral to HIV Prevention Counselor or to Prevention Case Manager)

Substance Use:

1. Has anyone ever told client they need treatment for drugs or alcohol?	**YES**_____	No_____
2. Does client feel that use of substances ever caused problems in his or her life?	**YES**_____	No_____
3. Is client currently using alcohol or other drugs?	**YES**_____	No_____
4. Has client ever sought treatment for alcohol or other drugs?	**YES**_____	No_____
5. Is client interested in substance treatment or other service?	**YES**_____	No_____

(If referral is needed, offer referral to a general substance treatment program for further assessment)

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CARE (Partner Notification) Needs:

1. Have all of client's past and present partners been notified that they are at risk? Yes_____ **NO**_____ **UNSURE**____
2. If yes, how were the partners notified? Client___ CARE Program____ Other____
3. Does client have concerns or fears about notifying partners? NA___ **YES**_____ No_____ Unsure_____
4. Is client aware that they can use the CARE program without revealing their identity? Yes_____ **NO**_____ **UNSURE**____
5. Has client had any contact with the CARE program? Yes_____ **NO**_____ **UNSURE**____

(If referral is needed, offer referral to CARE program: (860) 509-7920)

Needs of HIV-Affected Children:

1. Is the child having any difficulty in school or social situations? **YES**_____ No_____
2. Have the child's sleeping, eating or toilet-use patterns changed? **YES**_____ No_____
3. Is the child hiding food? **YES**_____ No_____
4. Has the child become unusually (for them) aggressive or irritable? **YES**_____ No_____
5. Has the child become unusually (for them) withdrawn, passive, weepy, or "clingy"? **YES**_____ No_____
6. Does client have any other concerns about the child's emotional well being? **YES**_____ No_____

(If "yes" to any of the above, offer referral to an HIV-Affected Children's Program for evaluation. If not available in your region, offer referral to a mental health or social service counseling facility. Please note that in this context "child" may be any child who is impacted by the serostatus of an HIV-infected client who is in a significant relationship with that child.)

	Client Accepts	**Declines**	**Does Not Need a Referral for:**	**Comments**
STD Testing	_____	_____	_____	_____
TB Testing	_____	_____	_____	_____
Risk Reduction counseling	_____	_____	_____	_____
Substance Use Assessment	_____	_____	_____	_____
CARE Program	_____	_____	_____	_____

(check appropriate line for each service)

Client Name_____
(print)
Client Signature_____
Date_____

(Revised 6/7/2002)