APLA
AIDS Project Los Angeles

PHYSICIAN DIAGNOSIS FORM

PHYSICIANS: *A licensed, practicing physician in Los Angeles County should complete as much of this form as possible. If you do not respond to a question, we will assume that you do not have an answer to that particular question. Return to the AIDS Project Los Angeles Registrar by fax at 213.201.1392 or mail to: AIDS Project Los Angeles, The David Geffen Center, 611 South Kingsley Drive, Los Angeles, CA 90005.*

Last Name [REDACTED] First Name [REDACTED] Middle Name

Date of Birth [REDACTED] (DATE) Social Security No. [REDACTED] – [REDACTED] – [REDACTED]

DIAGNOSIS: *(Choose only one)*

- ☐ HIV+ Asymptomatic (No Symptoms)
- ☑ HIV+ Symptomatic
- ☐ AIDS Asymptomatic (No Symptoms)
- ☐ AIDS Symptomatic

What was the date of this diagnosis? (DATE) **Year of first positive test for HIV:**

Symptoms that substantiate this diagnosis:

- ☐ Diarrhea
- ☑ Fevers
- ☑ Fatigue
- ☑ Other swollen lymph nodes, night sweats

Opportunistic infections that substantiate this diagnosis:

- ☐ CD4 < 200/14% (DATE)
- ☐ PCP (DATE)
- ☐ KS (DATE)
- ☑ Other pneumonia (DATE)

Current symptoms related to HIV disease or treatment include: tired, lost weight getting sick more often, experiencing fevers

LAB DATA: CD4 cell count ; CD4 percentage % as of (DATE)

HIV viral load as of (DATE)

Neutrophil count cells/mm3 as of (DATE)

OTHER ILLNESSES: Is there any other illness we need to be aware of? ☐ Yes ☐ No If yes, please describe:

KARNOFSKY SCALE ASSESSMENT: *(Please check the appropriate numerical value)*

☐ 100 = Stage I	☐ 80 = Stage I	☐ 60 = Stage II	☐ 40 = Stage III	☐ 20 = Stage III
☐ 90 = Stage I	☐ 70 = Stage II	☐ 50 = Stage II	☐ 30 = Stage III	☐ 10 = Stage IV

SKILLED NURSING CARE: Does this patient meet the nursing facility level of care? ☐ Yes ☐ No

DENTAL: Is this patient medically able to receive routine dental care and/or oral procedures? ☑ Yes ☐ No

TUBERCULOSIS: **Has this patient been screened for TB?** ☐ Yes ☐ No

TB skin test date ..... ☐ Positive ☐ Negative

TB chest X-ray date ..... ☐ Positive ☐ Negative

This patient is currently . . .

- ☐ Receiving preventative TB treatment
- ☐ Not receiving treatment
- ☐ Receiving treatment for active TB
- ☐ Non-compliant with recommended treatment

I am the physician responsible for the above patient's HIV care. I certify that the above information is correct and based on a review of the patient's HIV treatment needs.

[REDACTED] — Signature of Physician

10/06/2024 — Date Completed

[REDACTED] — Physician's Name

[REDACTED] — CA License #

[REDACTED] — Address

[REDACTED] — Phone

[REDACTED] — City

State Zip Code