



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 \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DATE

**DIAGNOSIS:** *(Choose only one)*

☐ HIV+ Asymptomatic (No Symptoms)

☐ HIV+ Symptomatic

☐ AIDS Asymptomatic (No Symptoms)

☐ AIDS Symptomatic

What was the date of this diagnosis? \_\_\_\_\_ Year of first positive test for HIV: \_\_\_\_\_  
DATE

**Symptoms that substantiate this diagnosis:**

☐ Diarrhea

☐ Fevers

☐ Fatigue

☐ Other \_\_\_\_\_

**Opportunistic infections that substantiate this diagnosis:**

☐ CD4 < 200/14% \_\_\_\_\_  
DATE

☐ KS

\_\_\_\_\_  
DATE

☐ PCP \_\_\_\_\_  
DATE

☐ Other \_\_\_\_\_  
DATE

**Current symptoms related to HIV disease or treatment include:** \_\_\_\_\_  
DATE

**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.*

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
CA License #

( )

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code