



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

☐ PCP _____
DATE

☐ KS _____
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