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)
- ☐ AIDS Asymptomatic (No Symptoms)
- ☑ HIV+ Symptomatic
- ☑ 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 burky loaths, super-sclude

**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:** fever and diarrhea

patient has burky loaths and super-sclude symptoms.

**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 2001-10-01 ..... ☐ Positive ☑ Negative

TB chest X-ray date 2001-10-01 ..... ☐ 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