

Patient Medical Evaluation/ Proof of HIV Status Form

Name of Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

D.O.B. _____ SSN (optional) ____/____/____

This form is required to be signed by the treating medical provider

Status: HIV + Date: _____ AIDS Date: _____

CD4 Count: _____ Date: _____ Viral Load: _____ Date: _____

Hepatitis B Vaccine: _____ Date: _____ Hepatitis C Test: _____ Date: _____

Syphilis Test: _____ Date: _____ TB Screening: _____ Date: _____

Current Medications with dosages: Date: _____

Date of last visit: _____ Date of next visit: _____

Comments: _____

Medical Provider's Printed Name

Signature

License Number

Hospital/Clinic

Telephone Number

**** If you are receiving this form it should be accompanied by a release of information. The information is necessary for reporting purposes and is required by our funder. Your assistance in returning this form as soon as possible is greatly appreciated. Thank you for your cooperation.