



LINKAGE AND RE-ENGAGEMENT PROGRAM REFERRAL FORM



Referring HIV Clinic Contact Information

Secure Fax Instructions: An official clinic fax coversheet must accompany the Referral Form, no Patient Identifying Information can be included on the coversheet

LRP Secure Fax Number: 1-213-382-7605 Attention to: _____
 LRP Provider Phone Line: 1-213-639-4288

Referring HIV Clinic Contact Information

Client Casewatch ID #: _____ Date of Referral: _____
 HIV Medical Clinic Name: _____ Address: _____
 Staff Name: _____ Phone: _____ Office Cell
 Staff Title: _____ Email Address: _____

Patient Contact Information

Patient Last Name: _____ First Name: _____ Middle Initial: _____
 AKAs: _____
 Date of Birth: _____ Gender: Male Female Transgender
 Last Known Address: _____
 Phone Number: _____ Home Cell Alternate Phone
 Number: _____
 Email Address: _____ SS#: _____ Medical Record #: _____

Patient's Emergency Contact (E/C) Information: **ONLY LIST IF E/C IS AWARE OF PATIENT'S HIV STATUS**

Name _____ Phone: _____ Email: _____
 Last HIV Medical Appointment Date: _____ Last VL Count: _____ copies/mL VL Date: _____

Contact Attempts Made

Phone Call(s) and Text Message(s) – Must have attempted at least 3 times within 2 weeks over the past 30 days

Phone Number Attempted: _____ Alternate Phone Number Attempted: _____
 Dates Attempted: (1st) _____ (2nd) _____ (3rd) _____

Results? Wrong Number Disconnected No Response Declined services at clinic

Letter Mailed to Last Known Address- Must have mailed 1 letter within the past 30 days Yes No

Date Mailed: _____



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Home Visit(s) – Must have conducted at least 1 home visit over the past 30 days after a letter was mailed and not returned back to sender

Home Visit(s) Conducted? Yes No Date(s) _____

Results? Not Home Doesn't Live There No Such Address/Address Invalid

Email(s) sent? Yes No Last Date Sent? _____

Results? Email Returned No Response

Other Services within the Clinic/Organization Contacted Yes No

If Yes, where? If No, why not? _____

Checked LASD Inmate Locator? Yes No Results? Not Incarcerated Patient Incarcerated

Notes: _____

Medical Care Coordination Services Summary Information:

Does your clinic have MCC services? Yes No

Has client ever been assessed by MCC team? Yes No Assessment Date: ____/____/____

Most Recent Acuity Level Severe High Moderate Self-Managed

Patient Issues: Mental Health Chronic Homelessness Substance Abuse History of Incarceration
 Hostility

Additional Notes: _____

Has the client been discharged from your clinic?

If yes, why? _____

DHSP – OFFICE USE ONLY

DHSP staff must verify that client received services at the referring clinic within the last 12-24 months

Accept Referral for LRP Program assignment? Yes No Casewatch/Client ID #: _____

If no, comment: Deceased In Care Elsewhere

Out of LA County Due Diligence not completed by provider