Las Vegas TGA Ryan White Part A HIV/AIDS Program

Medical Case Management Screening Tool

Please attach to client registration or reassessment form

Today's Date:	Client URN:	Assigned Case Manager:
Last Name:	First Name:	Middle Name:

HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider? ❑ Yes ❑No (provide referral) ❑ Just entering the care system (provide referral)

2. Date of last medical appointment? ___________________________ Date of next medical appointment? _______________________

3. Does the client have a copy of current labs (maximum of 6 months from today's date)? ❑ Yes ❑No

4. Please check all of the barriers to medical care that the client mentions:

❑ Just entering the care system	❑ Not ready to access care	❑ Afraid
❑ Homelessness	❑ Doesn't want to deal with it	❑ Feels fine/no symptoms
❑ Doesn't know where to go	❑ Couldn't get an appointment	❑ Drugs/Alcohol in the way
❑ Doesn't think it will help	❑ Clinic hours aren't convenient	❑ Child care unavailable
❑ Don't want people to know	❑ Doesn't like the doctors there	❑ No transportation
❑ Language barriers	❑ Lack of proper identification	❑ Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care? ❑ Yes ❑No ❑ Client Refused

If yes, where: ____

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication? ❑ Yes ❑No

2. Does the client currently take their medication? ❑ Yes ❑No ❑ Sometimes

3. How many doses has the client missed in the last month? ❑ 0 ❑1 ❑ 2 or more

If client reports missing doses please ask them why, (check all that apply):

❑ Doesn't want to deal with it/take meds	❑ Lack of social support	❑ Alcohol and/or Drug Use/Abuse
❑ Side effects	❑ Doesn't think meds work	❑ Medication regimen too complex
❑ Depression/Mental Health issues	❑ Can't get refills in time	❑ Alcohol and/or Drug Use/Abuse
❑ Too many pills	❑ Taste of medication	❑ Other:

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling? ❑ Yes ❑No ❑ Client Refused

If yes, where : ____

Notes:

NUTRITION SCREENING

1. What is your current weight and height? ______ feet ______ inches ________ weight

2. Without wanting to, have you experienced significant weight loss in the last 6 months? ❑ Yes ❑No

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3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression? ❑ Yes ❑No ❑Other: ______________________________

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)? ❑ Yes ❑No

5. Do you have access to food? ❑ Yes ❑No

Referral provided for Medical Nutrition Therapy or other food provider? ❑ Yes ❑No ❑ Client Refused

If yes, where: ____

Notes:

CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?

❑ Yes (stop here) ❑Never used either substance (stop here) ❑No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use? ❑ Yes ❑No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use? ❑ Yes ❑No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use? ❑ Yes ❑No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener? ❑ Yes ❑No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.

Referral provided for Substance or Alcohol abuse? ❑ Yes ❑No ❑ Client Refused

If yes, where: ____

Notes:

EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL

Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?

❑ Yes (stop here) ❑No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see? ❑ Yes ❑No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things? ❑ Yes ❑No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment? ❑ Yes ❑No ❑ Client Refused

If yes, where: ____

Notes: