Print Form

Medical Case Management Record

Instructions:

1. **Upon initial medical case management client encounter, complete "Section I, Intake and Engagement".**
2. **Within 30 days of completion of the intake, complete "Section II, Assessment". Verify if any changes have occurred in Section I since the initial intake.**
3. **Reassessment is required every 180 days or sooner if a significant life change occurs.**
4. **Reassessment requires verification of information in Sections I and II and updates as needed.**

Note: If using an EMR, this paper copy may be a useful tool for documentation of the face-to-face encounter with a client and subsequent entry into the EMR.

I. INTAKE AND ENGAGEMENT

Client Demographics

Date presented at clinic:_____ Date intake/engagement form completed: _____

Chart #: _____

Identification

SSN: _____ Case #: _____

Last name: _____ First: _____ Middle: _____

AKA: _____

DOB: _____ Age at intake: _____

Address & Contact Information

Street: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime phone #: _____ Evening phone #: _____ Cell phone #: _____

This person may be contacted (check all that apply):

☐ By mail ☐ Home visit ☐ By phone ☐ By email

Gender

☐ Male ☐ Female ☐ Transgender: Female ID as male ☐ Transgender: Male ID as female

Ethnicity and Race

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Race: ☐ White
☐ Black/African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Some Other Race

Drug/Substance Use

Substance	Age First Started	Frequency of Use	Date Last Used	Sex with Use
Cigarettes				
Alcohol				
Marijuana				
Cocaine (nasal)				
Cocaine (smoke)				
Cocaine (inject)				
Heroin (nasal)				
Heroin (smoke)				
Heroin (inject)				
Meth (smoke)				
Meth (inject)				
Meth (pills)				
Ecstasy				
Rx Pills				
Mushrooms				
Poppers/inhalants				
Other				

Ever shared needles/works/equipment for:

Injection of drugs: ☐ Yes ☐ No
Injection of hormones: ☐ Yes ☐ No
Tattooing: ☐ Yes ☐ No
Body Piercing: ☐ Yes ☐ No
Self-mutilating: ☐ Yes ☐ No

Financial/Household Information

Employment Information

Employed ☐ Yes ☐ No If yes:

Name of employer:_____ Phone number: _____

Address: _____ Average monthly income: _____

_____ Active health insurance: ☐ Yes ☐ No

Insurance Information

Medicaid #: _____ Managed Care: _____

Other insurance: _____

Emergency Contact

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Daytime phone #: _____ Evening phone #: _____ Cell phone #: _____

Is contact aware of patient's HIV status? ☐ Yes ☐ No

Living Situation

Head of household? ☐ Yes ☐ No

Dependent children living with client? ☐ Yes ☐ No

Dependent adult living with client? ☐ Yes ☐ No

Household Data

Household size: _____

Total annual income: _____

☐ Client Refused to Answer

Household members

Name	Sex/ Age	Relationship	HIV Status	If child is a household member, is the child aware of their own HIV status?	Is household member aware of patient's HIV status?	Medical Care Provider
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	

Describe any parenting issues, such as ACS/Child Protective Services involvement or child care needs.

Current spouse or partner not listed as household member? ☐ Yes ☐ No

Spouse/partner's status:_____

Spouse/partner aware of patient's HIV Status? ☐ Yes ☐ No

Other disclosure issues?

Housing/Transportation

Housing

Current housing situation:

Is client adequately housed? ☐ Yes ☐ No

Transportation

Access to transportation? ☐ Yes ☐ No

Usual method of transportation to the clinic: _____

Assistance with accessing reliable transportation to medical appointments required? ☐ Yes ☐ No

HIV Status / Medical Care

HIV/AIDS Status

Lab confirmation of HIV status? ☐ Yes ☐ No

HIV+/Not AIDS ☐ Yes ☐ No VL: _____ Date taken: _____ Unknown: _____

HIV+/AIDS Status Unknown ☐ Yes ☐ No CD4 count: _____ Date taken: _____ Unknown: _____

AIDS ☐ Yes ☐ No Date of diagnosis: _____

When/where did client receive initial diagnosis? _____

Date of last HIV primary care visit: _____ Frequency of primary care visits: _____

Previous HIV primary care medical provider: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Length of care with provider: _____

Reason for terminating care: _____

Recent hospitalizations? ☐ Yes ☐ No

Hospital(s): _____ Duration of stay(s): _____

Nature of hospitalization(s): _____

Current Specialty Medical Care Providers (including primary care provider, if applicable)

Name	Type of Provider	Address	Phone

HIV Related Medications

Name of Medication	Currently or Previously Taken (C/P)	Frequency	Side Effects

TB status: ☐ Positive ☐ Negative ☐ Unknown Date of last TB test: _____

If positive, list medications: _____

Hepatitis: HCV infected? ☐ Yes ☐ No ☐ Unknown If No, date of last HCV test: _____

Treatment: _____

HBV infected? ☐ Yes ☐ No ☐ Unknown If No, date of last HBV test: _____

History of HBV Vaccination? ☐ Yes ☐ No If yes, date: _____

Treatment: _____

Other medical conditions? ☐ Yes ☐ No If Yes, specify: _____

Other Medications

Name of Medication	Currently or Previously Taken (C/P)	Frequency	Side Effects

Immediate medical needs, e.g. need for medication or acute care:

Barriers to accessing medical care:

Current Community Case Management and other Supportive Services Providers

Name	Type of Provider	Address	Phone	Fax	Email

Consents and Authorizations for Release of Confidential Information

- ☐ Previous medical provider ☐ _____
- ☐ Community case manager ☐ _____
- ☐ Substance use treatment provider ☐ _____
- ☐ Mental health provider ☐ _____
- ☐ Subspecialty care ☐ _____
- ☐ HASA/Public assistance
- ☐ Consent for enrollment in medical case management
- ☐ Family, partner, friend

Intake and Engagement Completed: _____ _____
Date **Medical Case Manager Signature**

Supervisory Review (if required): _____ _____
Date **Supervisor Signature**

II. ASSESSMENT/REASSESSMENT

Women's Health Issues

Date of last GYN exam: _____ Date of last PAP smear: _____ Results: _____

Date of last Anal Pap exam: _____ Date of last breast exam: _____

Date of last Mammogram: _____

STI history: _____

Preconception/family planning needs:

Pregnant? ☐ Yes ☐ No

If yes: Estimated # of weeks: _____

Prenatal care site: _____

Education on mother-to-child transmission (MTCT) provided? ☐ Yes ☐ No

If yes, MTCT education/information must be included in the service plan.

Men's Health Issues

Date of last anal pap exam: _____

Date of last testicular exam: _____

Date of last prostate exam: _____

STI history: _____

Preconception/family planning needs:

Transgender Health Issues

How does client identify? _____

HRT (hormone replacement therapy)? ☐ Yes ☐ No

If yes, date started: _____

How does the client access HRT? _____

Name/address of physician, if other than PCP? _____

_____

Is client's regular PCP aware of HRT? ☐ Yes ☐ No

Date of last Anal Pap Exam: _____

STI History: _____

Dental Health Issues

Receives ongoing dental care? ☐ Yes ☐ No

If yes, date of last visit: _____

Provider: _____

Address: _____

_____

Phone: _____

Nutrition

Receiving food assistance? ☐ Yes ☐ No

Appetite, diet, nutritional needs, supplements:

Has client experienced a significant weight change recently? ☐ Yes ☐ No

If yes, explain:

Need for additional food resources? ☐ Yes ☐ No

If yes, explain:

Home Care

Client currently receiving home care? ☐ Yes ☐ No

If no, is client in need of an evaluation for home care services? ☐ Yes ☐ No

If yes, complete the following:

Home care agency: _____

Name of nurse/aide: _____

Describe existing home care services and frequency of home care needs:

Education/Language

Highest grade/degree of education completed: _____

Language(s) spoken fluently: _____

Preferred language: _____

Read English? ☐ Yes ☐ No Read (other)? ☐ Yes (specify) _____ ☐ No

Write in English? ☐ Yes ☐ No Write (other)? ☐ Yes (specify) _____ ☐ No

Date client assessed for health literacy: _____

Describe health literacy needs:

Financial Resources/Entitlements

Changes in sources of income? ☐ Yes ☐ No

If yes, describe:

Need for resource assistance? ☐ Yes ☐ No

If yes, describe:

Note any changes in contact information for DSS or private health insurance:

Domestic Violence

Does client feel **unsafe** in current living situation? ☐ Yes ☐ No

If yes, describe:

Is there a history of physical/sexual abuse/assault? ☐ Yes ☐ No

If yes, describe:

Is client currently in a program that is addressing domestic violence issues? ☐ Yes ☐ No

If yes, explain:

If client does not believe that violence is an issue, does worker have any reason to believe that this is an issue?

☐ Yes ☐ No

If yes, explain:

Mental Health

Mental Health History

History of mental health hospitalizations? ☐ Yes ☐ No

If yes, explain:

History of trauma, psychiatric or mental health treatment? ☐ Yes ☐ No

If yes, what diagnosis(es) given:

If yes, what symptoms were presented?

Currently receiving mental health or psychiatric treatment (i.e. individual or group treatment, family counseling, psychiatric care)? ☐ Yes ☐ No If yes, frequency: _____

If yes, treatment provider(s)

Name	Address	Phone	Fax	Email

Mental health medications

Name of Medication	Currently or Previously Taken (C/P)	Frequency	Side Effects

Substance Use

Note: If HCV infected, counsel on alcohol use.

Substance and Alcohol Use Assessment

Substance	Age First Started	Frequency of Use	Date Last Used	Sex with Use
Cigarettes				
Alcohol				
Marijuana				
Cocaine (nasal)				
Cocaine (smoke)				
Cocaine (inject)				
Heroin (nasal)				
Heroin (smoke)				
Heroin (inject)				
Meth (smoke)				
Meth (inject)				
Meth (pills)				
Ecstasy				
Rx Pills				
Mushrooms				
Poppers/inhalants				
Other				

Ever shared needles/works/equipment for:

Injection of drugs:	☐ Yes	☐ No
Injection of hormones:	☐ Yes	☐ No
Tattooing:	☐ Yes	☐ No
Body Piercing:	☐ Yes	☐ No
Self-mutilating:	☐ Yes	☐ No

* Please refer to Addiction Screening, Brief Intervention and Referral to Treatment ***(SBIRT)*** for additional information.

HIV Prevention with Positives

Primary HIV risk at diagnosis:

Perinatal	☐	Sex involving transgender	☐
IDU	☐	Heterosexual contact	☐
MSM	☐	Other/risk not identified	☐

Current HIV risk:

IDU	☐	Sex involving transgender	☐
MSM	☐	Heterosexual contact	☐
MSM/IDU	☐		

Sexual Behavior History (in the past 3 months):

different male partners: _____
different female partners: _____
different MTF or FTM partners: _____
% condom use for:
Oral Sex_____
Rectal Sex_____
Vaginal Sex_____
Partner(s) know your HIV status: ☐ Yes ☐ No

		Yes	No
Oral-Genital Sex			
Oral-Anal Sex			
Rectal Sex	Receptive ☐ Insertive ☐		
Vaginal Sex			

Describe risk reduction activities:

Partner Services

Does client need assistance with disclosure? ☐ Yes ☐ No

If yes, describe:

Has current partner been HIV tested? ☐ Yes ☐ No

If no, why? _____

Is New York State Department of Health Partner Services or New York City Department of Mental Health and Hygiene Contact Notification Assistance Program (CNAP) intervention required? ☐ Yes ☐ No

Legal

History of being incarcerated or in a juvenile detention facility? ☐ Yes ☐ No

If yes, describe: _____

Client currently on probation or parole? ☐ Yes ☐ No

If yes, describe? _____

Is client in need of assistance with:

		Comments
Health care proxy/ Living will?	☐ Yes ☐ No	_____
Power of attorney?	☐ Yes ☐ No	_____
Immigration?	☐ Yes ☐ No	_____
Permanency planning?	☐ Yes ☐ No	_____
Standby guardianship?	☐ Yes ☐ No	_____
Other?	☐ Yes ☐ No	_____

Reassessment Log

	Date	Case Manager Signature	Supervisor Signature
Initial Assessment			
Reassessment			
Reassessment			
Reassessment			
Reassessment			
Reassessment			
Reassessment			