MANITOBA
HIV PROGRAM

PROGRAM TO ACCESS TREATMENT FOR HIV AND SUPPORT (PATHS) REFERRAL FORM

Today's date (dd/mmm/yyyy):	
REFERRING PROVIDER INFORMATION	
First and last name:	
Phone Number:	Fax Number:
MB HIV Program site of care:	
Most responsible physician (MRP) first and last name:	
☐ Patient is open to or has been referred to Public Health	
PATIENT INFORMATION	
Last name:	First name:
Date of Birth (dd/mmm/yyyy):	Language:
PHIN:	MHSC:
Sex at birth: ☐ Male ☐ Female	Pronouns:
CARE INFORMATION	
Specimen date of positive HIV test (dd/mmm/yyyy):	
Last time care was provided in clinic (dd/mmm/yyyy):	
Client last seen by (practitioner name):	
Last CD4 count date (dd/mmm/yyyy):	Last CD4 count value:
Last viral load test date (dd/mmm/yyyy):	Last viral load value:
Last record of antiretroviral (ART) medication (dd/mmm/yyyy):	
Current substance use:	OAT:
Additional Comments:	
Primary Care Provider name:	
Phone number:	Fax number:
Previous medical history (if available)	
Pharmacy:	
Phone number:	Fax number:
PATIENT ENGAGEMENT STATUS	
☐ Never linked to care	
☐ Disengaged in care	
☐ Lost to care	
☐ Linked/retained to care (provide additional information for referral below):	
☐ Pregnant ☐ Houselessness ☐ Recurrent STBBIs ☐ Untreated mental illness ☐ Substance use disorder	☐ High utilization of Emergency Dept/inpatient admissions ☐ Post incarcerations with history of treatment interruptions upon release. ☐ Target not detected & no bloodwork in >6 months & non-adherence to dispensed ART medications ☐ Other ______________________________

PHYSICAL DESCRIPTION					
☐ Unknown	Height: ☐ Tall ☐ Medium ☐ Short	Build: ☐ Heavy ☐ Medium ☐ Thin	Eye Colour: ☐ Blue ☐ Green ☐ Hazel ☐ Brown	Other Features: ☐ Glasses ☐ Piercing ☐ Scars ☐ Facial Hair ☐ Tattoo	Additional Information:

LOCATING INFORMATION	
Last Known address (street number, name):	
Date (dd/mmm/yyyy):	Outcome (letter sent, marked 'return to sender', etc):
Connections to other communities (band, known to frequent rural community):	Social media account (Instagram, Facebook, etc):
Email Address:	

COMMUNITY SERVICES	
☐ Street Connections ☐ RAY ☐ Main Street Project ☐ Siloam ☐ N'Dinawemak ☐ Community Living Disability Services (CLDS) Community Service worker: ________________ ☐ Life's Journey Support worker: ___________________ ☐ Turning Leaf Support worker: ____________________	☐ EIA ☐ Program Assertive Community Treatment (PACT) ☐ Assertive Community Treatment (ACT) ☐ Sage House ☐ Nidinawe ☐ Salvation Army ☐ HOCS ☐ Other: ___________________

Fax completed referrals to the MB HIV Program to 204-318-3181

If you have not been contacted within five business days or you have questions regarding eligibility, contact the Client Engagement Coordinator at 1-866-449-0165.