MANITOBA HIV PROGRAM

MANITOBA HIV PROGRAM REFERRAL FORM

The testing practitioner must notify patients who test positive for HIV.

All persons who test positive for HIV should be referred to the Manitoba HIV Program with patient consent.

Today's date (dd/mmm/yyyy):

PATIENT INFORMATION

Last name:	Street address:
First name:	City/town/community:
MB Health #:	Postal code:
PHIN:	Can the patient travel to any of the below for HIV care? ☐ Brandon ☐ Thompson ☐ Winnipeg
Date of birth (dd/mmm/yyyy):	Primary phone number: Can we leave a confidential voice message? ☐ Yes ☐ No
Sex at birth: ☐ Male ☐ Female	
Gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Two spirit ☐ Other _____ ☐ Prefer not to specify	Email:
	Social media handle:
	Preferred language: Interpreter required: ☐ Yes ☐ No
New HIV diagnosis: ☐ Yes ☐ No Specimen date of positive HIV test in Manitoba (dd/mmm/yyyy): Date and location of positive HIV test if outside of Manitoba (dd/mmm/yyyy):	Acute symptoms (consult MB HIV Program if signs of serious illness, advanced HIV or opportunistic infections):

Referral package checklist: Attach baseline investigations as per the *Manitoba HIV Program Primary Care Recommendations for the Management of Adults Living with HIV in Manitoba*: https://mbhiv.ca/healthcare-providers/guidelines/

☐ Medical history (medications, allergies, psychosocial, etc)	☐ Comorbid conditions (TB, Hepatitis, etc)
☐ HIV test result	☐ STBBIs
☐ Other HIV specific test results (CD4 cell count, HIV viral load, etc)	☐ Non-infectious comorbidities

Notes (additional contact information, booking considerations, incarceration, hospital admission, etc.):

PROVIDER INFORMATION

Referring provider first and last name:	Phone number:	Fax number:
Primary care provider first and last name (if different from above):	Phone number:	Fax number:

☐ Patient does not have a primary care provider and consents for MB HIV Program to submit a referral to *Family Doctor Finder* or directly to a primary care provider on their behalf **(please complete page 2)**

Once referral is received, the MB HIV Program may contact the patient to help determine the best site for care. The care site will contact the patient to book a comprehensive HIV intake and initiate HIV treatment. Once patient is stable on treatment, with consistent viral load suppression, the MB HIV Program will provide recommendations to primary care providers for ongoing treatment and monitoring.

REFER PATIENTS BY FAX TO: 204-318-3181

CONSULT: 1-866-449-0165

MANITOBA HIV PROGRAM

MANITOBA HIV PROGRAM REFERRAL FORM

THIS PAGE MUST BE COMPLETED IF THE PATIENT NEEDS A CONNECTION TO PRIMARY CARE

Does the patient self-identify as First Nations, Métis, or Inuit?

- ☐ First Nations:
  - ☐ Status ☐ Non-Status
- ☐ Métis

  Any particular Métis nation? _____
- ☐ Inuit
- ☐ Patient does not self-identify as First Nations, Métis, or Inuit

Other patient characteristics (please check all that may apply):

- ☐ Identifies as a gay, bisexual, or queer man who has sex with men
- ☐ Injects drugs
- ☐ Has a history of substance use disorder
- ☐ On Opioid Agonist Treatment (OAT)
- ☐ Has unprotected sex with multiple partners
- ☐ From a country where HIV is endemic
- ☐ Lives in poverty and/or is experiencing houselessness
- ☐ Lives in the Downtown-Point Douglas area of Winnipeg
- ☐ Justice Involved
- ☐ Experiencing serious and persistent mental illness
- ☐ High utilization of emergency departments and/or tertiary care settings

Does the patient have accessibility needs that should be considered?

- ☐ Mobility (wheelchair access, difficulty with stairs, etc)
- ☐ Visually impaired
- ☐ Hearing impaired
- ☐ Other: _____
- ☐ No accessibility needs

Preferred gender(s) of primary care provider? ☐ Male ☐ Female ☐ X

Is the patient *willing* to see a primary care provider of any gender? ☐ Yes ☐ No

What city/town/community does the patient want to access primary care in?

- ☐ Brandon
- ☐ Thompson
- ☐ Winnipeg
- ☐ Other: _____

If within Winnipeg, what neighborhood(s) would client like to access primary care in?