WOMEN'S INTERAGENCY HIV STUDY

REFERRAL CHECKLIST FOR ABBREVIATED VISIT

AFFIX ID LABEL HERE --->

A1. PARTICIPANT ID: ENTER ID NUMBER ONLY IF ID LABEL IS NOT AVAILABLE

|__| - |__|__| - |__|__|__|__| - |__|

A2. WIHS STUDY VISIT #: ___ ___

A3. FORM COMPLETED BY: ___ ___ ___

INSTRUCTIONS: USE AS A CHECKLIST TO INDICATE WHERE TO REFER PARTICIPANT FOR FURTHER EVALUATION/ASSISTANCE.

a. QUESTION NUMBER		b. REASON FOR REFERRAL	c. REFER TO:
☐	B1	IF LIVING ON STREETS/BEACH	SOCIAL SERVICE PROVIDER
☐	B3a	IF FEVER OF >100 DEGREES FAHRENHEIT FOR > ONE MONTH	MEDICAL PROVIDER
☐	B3b	DIARRHEA > ONE MONTH STRAIGHT	MEDICAL PROVIDER
☐	B3c	MAJOR PROBLEMS WITH MEMORY OR CONCENTRATION >2WEEKS	MEDICAL PROVIDER
☐	B3d	NUMBNESS, TINGLING, BURNING IN ARMS, LEGS, FEET, >2WKS	MEDICAL PROVIDER
☐	B3e	CONFUSION, UNABLE TO PERFORM ROUTINE TASKS	MEDICAL PROVIDER
☐	B3f	DRENCHING NIGHT SWEATS	MEDICAL PROVIDER
☐	C4c	HAVING BLEEDING BETWEEN PERIODS	HEALTH CARE PROVIDER
☐	C8a	USED MARIJUANA/HASH	COUNSELOR
☐	C8b	USED METHADONE	COUNSELOR
☐	C8c	USED CRACK	COUNSELOR
☐	C8d	USED COCAINE	COUNSELOR
☐	C8e	USED HEROIN	COUNSELOR
☐	C8f	USED ANY OTHER DRUG	COUNSELOR
☐	C9	INJECTED DRUGS DURING PAST 6 MONTHS	COUNSELOR
☐	C10	SHARED NEEDLES DURING PAST 6 MONTHS	COUNSELOR