St. Mary's Center
We help you to help yourself

512 West 126th Street
New York, NY 10027
PH (212)665-5992
FX (212) 665-5892 / (646) 619-6272

Adult Day Health Care Program Referral From

Name

Phone

Address

Date of Birth

SS#

Medicaid

Date of HIV Diagnosis

Most Recent Viral Load

Most Recent CD4 Count

Date of AIDS Diagnosis

Date

Date

Please attach a copy of latest lab reports (CD4, Viral load, Chemistry, Hematology & Lipid Panel), Immunization hx, and Proof of Status (positive antibody test or detectable viral load or M11Q)

HIV / AIDS Related Conditions?

☐ YES ☐ NO

If yes, please list

Chronic Medical Conditions?

☐ YES ☐ NO

If yes, please list

Allergies?

☐ YES ☐ NKA

If yes, please list

Date of Latest PPD or Quantiferon
(*within 12 months*)

Results:

☐ **POSITIVE** ☐ **NEGATIVE**

TB Status—History of TB?

☐ **YES** ☐ **NO**

If yes, please indicate treatment date & type

Latest Chest x-Ray Date
(*within 12 months*)

Results

Please attach copy of Radiology Report

I am referring the above named patient to Saint Mary's Adult Day Health Care Program who has a diagnosis of

☐ **HIV** ☐ **AIDS**

I believe that my patient will benefit from one or more of the services provided. I am aware that certain medical information regarding the referred patient must be forwarded to Saint Mary's Center within 30 days of this referral and that periodic updates of CD4, Viral Load and other aspects are required by the NYS DOH AIDS Institute.

Physician's Name

☐ **MD**

License #

Phone

Address

Fax

Physician's Signature

Date

Please address all correspondence to ext.

Please email completed form to agueits@stmaryscenterinc.com