CONFIDENTIAL REQUEST FOR LOCAL HEALTH DEPARTMENT ASSISTANCE FOR PARTNER SERVICES

Use of this form will allow *providers to refer HIV/AIDS infected individuals or sex and needle-sharing partners to local health departments for assistance with Partner Services (PS). Upon receipt of this form attempts will be made to confidentially contact and provide appropriate counseling, testing or referrals (CTR). This form **does not** replace the required use of the HIV/AIDS Case Report (1355) to report positive test results. However, this form can be a useful tool to refer those individuals who request anonymous reporting.

(*Check only one*):

1. ☐ **HIV/AIDS-Infected Individual** ☐ **At-Risk Partner**

2. **Individual's name: (Last) (First) (MI)**

3. **Street Address: Home/Alternative Phone Number:**

4. **City: State: Zip Code: County**:

5. **Place of Employment: Work Phone Number:**

6. **Sex**:

- ☐ Male
- ☐ Female
- ☐ Transgender

Pregnant

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not Applicable

7. **Marital Status**:

- ☐ Married
- ☐ Single
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Domestic Partner
- ☐ Unknown

8. **Date of Birth**:

_____/_____/_____
month day year

Age: _____

9. **Race**: (*Check all that apply*)

- ☐ White
- ☐ African-American
- ☐ Arab/Chaldean
- ☐ Asian
- ☐ Hispanic ☐Yes ☐ No ☐ Not Applicable
- ☐ Hawaiian/PI
- ☐ Native American
- ☐ Unknown

10. **LaboratoryTest**: Section reserved for HIV diagnosed individual (Check all that apply :)

- ☐ Elisa/ Rapid Test
- ☐ Western Blot
- ☐ Other Test
- ☐ CD4 Count
- ☐ Viral Load

Other :_____

Individual Informed of results? ☐ Yes ☐ No

11 **Referral Provider Name**

12. **Facility Address: Office Phone:**

13. **City: State: Zip Code: County**

14**. Person making referral other than provider:**

Name: _____

Phone : _____

15. **Date of Referral**:

_____/ _____/ _____
month day year

16. **Provide any additional information**:

(Indicate Infected Client's Unique Identification Number: _____)

17. Ma**il to**: (Indicate Address of Appropriate Local Public Health Department):

Address:_____ City:_____ State:_____ Zip Code:_____

Attention: _____ Phone Number: _____

Secured Fax #: _____

Local public health department retention of this form shall not exceed 90 days from the date of receipt.

*** Providers are anyone who performs CTR or medical evaluations for individuals diagnosed for HIV and found to be positive.**

DCH-1221 (Rev. 4-03) (W) Obsoletes form HP-139