CONFIDENTIAL REQUEST FOR LOCAL HEALTH DEPARTMENT ASSISTANCE FOR PARTNER SERVICES

Use of this form allows *providers to refer persons diagnosed as having HIV/AIDS or an at-risk sex/needle-sharing and/or cluster/network partner to a local health department for assistance with Partner Services (PS). Upon receipt of this form attempts will be made to confidentially contact and provide prevention counseling, testing and/or referrals (CTR) to medical and other support services. This form can be a useful tool to also refer an index client for PS who have requested anonymous versus confidential HIV case reporting. ***Completion of this form <u>does not</u> replace the required submission of the HIV/AIDS Case Report (DCH-1355) to report positive test results.***

(*Check only one*): *Circle if cluster/social network*

1. ☐ **Index client** ☐ **At-Risk Partner/Cluster/Social Network**

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

3. **Street Address:** **Home/Alternative Number (Cell)**

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

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

6. **Sex at Birth**: ☐ Male ☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Trans to Female
☐ Trans to Male

Pregnant:
☐ Yes ☐ Unknown
☐ No ☐ Not Applicable

7. **Marital Status**:
☐ Married
☐ Single
☐ Divorced/Separated
☐ Widowed
☐ Lives/wPtnr
☐ Unknown

8. **Date of Birth**:

_____/_____/_____
month day year

Age: _____

9. **Race**: (*Check all that apply*)
☐ White ☐ Hispanic ☐Yes ☐ No ☐ Not Applicable
☐ Black (African-American) ☐ Native Hawaiian/PI
☐ American Indian/Alaskan
☐ Asian

Ethnicity: Arab ☐ Y ☐ N ☐ Unknown Latino/Hispanic ☐ Y ☐ N ☐ Unknown

(*Complete box for Index client only)*

10. **Confirming Laboratory Test Result Reported to MDHHS HIV/AIDS Surveillance**:

☐ Yes ☐ No, Supplemental Pending

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 Index Client's Unique Identification Number **<u>only</u>** if referring at-risk partner: _____)

17. Ma**il to**: (Indicate Address of Appropriate Local 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 as having HIV and found to be positive.**