

**INSTRUCTIONS FOR COMPLETING THE
CONFIDENTIAL REQUEST FOR LOCAL HEALTH DEPARTMENT ASSISTANCE FOR PARTNER
SERVICES DCH-1221**

Michigan Compiled Law, 333.5114a and 333.5131, allows for physicians and local health officers to refer persons diagnosed with HIV/AIDS and/or their sex and needle-sharing contacts/partners to local public health for assistance with partner services. By completing and submitting the attached form to a local public health department, attempts will be made to confidentially contact the individual and provide HIV/AIDS prevention information and linkage to care services, and in the case of a partner, testing or test referral. This form can also be useful when referring individuals living with HIV/AIDS who have elected anonymous versus confidential case reporting to surveillance. Please use separate sheets for each type of referral. *Copies of this form are available through your local public health department.*

INSTRUCTIONS:

- Line 1.** Please mark the appropriate box designating your request for assistance with partner notification for the individual diagnosed as having HIV/AIDS (**Index Client**), or an **At-Risk Sex or Needle-Sharing Partner**. Circle if referring a **cluster/social network partner**. This is an individual who is not a direct at-risk partner, but someone who might benefit from counseling and testing because of their close association with a person diagnosed as having HIV/AIDS.
- Line 2. Name:**
Enter the full name (last, first) of the individual you are referring for assistance with partner services.
- Line 3. Street Address/Phone:**
Enter the residential address and street name of the individual being referred.
Also, indicate a home or alternate telephone number.
- Line 4. City/State/Zip Code/County:**
Indicate the name of the city, state, zip code and county, of residence for the individual being referred.
- Line 5. Place of Employment/Phone:**
Enter the place of employment and telephone number for the individual being referred.
- Line 6. Sex/Gender/Pregnant Status:**
Indicate the sex at birth of the individual being referred, and current gender status. Also indicate the pregnancy status of the female
- Line 7. Marital Status:**
Indicate the marital/cohabitating status of the individual being referred.
- Line 8. Date of Birth/Age:**
Enter the date of birth and age of the individual you are referring.
- Line 9. Race and Ethnicity:**
Enter the race/ethnicity of the individual you are referring.
- Line 10. Laboratory Test/Individual Informed of Result:**
Indicate if confirming HIV test results were reported to HIV/AIDS Surveillance, and if the individual was informed of the results.
- Line 11. Referral Provider Name:**
Indicate the name of the provider who is making the referral.
- Line 12/13. Facility Address/ Phone/City/ State/Zip Code/County:**
Indicate the facility address, telephone number, name of the city, state, zip code, and county.
- Line 14. Person making referral other than provider:**
Enter the name and phone of the person, if different than the physician who is making the referral e.g., nurse, counselor, case manager.
- Line 15. Date of Referral:**
Enter the month, day and year of the referral.
- Line 16. Provide Any Additional Information:**
Document any other information (environmental, medical, physical, psychological, which may be important to the care of this individual. Provide the unique identifier number (UIN) of the index client if making a referral for a risk partner.
- Line 17. Mail To:**
Enter the mailing address of the health department, the name, and phone number of the designee who will receive this referral. In most counties, this individual is usually the HIV/AIDS Coordinator. Only indicate the fax number if the referral will be sent to the health department via a secured fax number.
- Note:** *All notification efforts conducted by local public health are confidential. At no time will the name of the Index Client be disclosed to an identified partner.*

