Project New Hope/Homestead Division
HIV/AIDS Diagnosis Form

Date: _____ Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ **SEX:** Male Female Other

RACE/ETHNICITY: White Black Hispanic Other

ETIOLOGY: Homosexual Bisexual Hemophiliac IV Drug Abuse Blood Transfusion
Heterosexual

DIAGNOSIS: HIV Asymptomatic HIV Symptomatic Date: _____ AIDS Symptomatic Date: _____

Symptoms Include: _____

Opportunistic Infections (give dates)

CD4 _____	Has patient been screened for TB?	Yes	No
KS _____	TB Skin Test Date:	Positive	Negative
PCP _____	TB Chest X-ray Date:	Positive	Negative
Other _____			

Is Patient currently receiving preventive TB Treatment? Yes No
Is Patient receiving treatment for Active TB? Yes No

Karnofsky Scale Assessment:

Stage I:	71-100	100	Normal, no complaints, no evidence of disease
		90	Able to carry on normal activity, minor signs or symptoms of disease
		80	Normal activity with effort, some signs or symptoms of disease
Stage II:	51-70	70	Cares for self. Unable to carry on normal activity or do active work
		60	Able to care for most needs; requires occasional assistance
Stage III:	31-50	50	Requires considerable assistance and frequent medical care
		40	Disabled, requires special care and assistance
Stage IV:	10-30	30	Severely disabled, hospitalization is indicated. death not imminent
		20	Very ill; active supportive treatment
		10	Moribund, fatal processes progressing rapidly

What is the client's actual Karnofsky Score? _____

Does the client meet Nursing Facility Level of Care? Yes No

Observation on an ongoing intermittent basis and 24hr supervision to meet his or her health needs
Required professional nurse observation for response and effect on an intermittent basis
Need encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence

Vision, hearing or sensory loss
Limitation in movement
Incontinent of urine and/or bowels
Mild confusion or depression
Requires assistance or supervision in personal care

I certify that I am the personal physician of (client's name): _____

Physician Signature: _____ Date: _____

Physician Name (Please Print): _____ **License #:** _____

Address: _____ Phone: _____