

OHDAP PHYSICIAN VERIFICATION FORM

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| Patient Last Name: | Last 4 Digits of SSN: |
| Patient First Name: | DOB: |
| Latest CD4+ Count: | Date: |
| Latest Viral Load: | Date: |
| Lab results (CD4 and viral load measures) are pending for bloodwork sent to the lab on: | Date: |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> Date Patient First Tested HIV Positive: <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em; margin-top: 5px;"></div> </div> <div style="width: 55%;"> <p>Please check appropriate answer:</p> <p>HIV-positive test result self-reported by client.</p> <p>HIV-positive test result confirmed by another source.</p> <p>HIV-positive test result confirmed by test conducted in your office</p> </div> </div> | |

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| 1. Does this patient have private medical insurance? | YES | NO |
| 2. Has the patient been referred to an AIDS Clinical Trials Group? | YES | NO |
| a. Is the patient receiving any medications through Clinical Trials? | YES | NO |
| 3. Are you prescribing ARVs for this patient? | YES | NO |
| 4. Are you prescribing medication from the OHDAP formulary for this patient? | YES | NO |
| 5. Is the patient currently ART naïve? | YES | NO |
| 6. Does the patient have CDC-defined AIDS? | YES | NO |

HIV Disease Staging (Check appropriate box below for this patient's LOWEST historic lab results)

Stage 0 Negative or indeterminate result within 180 days of a positive result

Stage 1 (CD4+ ≥500 cells/ μL)

Stage 2 (CD4+ <500 cells/mL but >200 cells/ μL)

Stage 3 (CD4+ <200 cells/ μL)

Unknown Positive HIV test result, but no additional information such as CD4+ count

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| Prescriber Last Name: | Prescriber Phone Number: |
| <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div> | <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div> |
| Prescriber First Name: | Prescriber E-Mail Address: |
| <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div> | <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div> |
| Prescriber Signature: | <div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <p>For OHDAP/Case Management only:</p> <p>Scan document as medical attachment.</p> </div> |
| Date: | |
| <div style="border-bottom: 1px solid black; width: 100%; height: 1.2em;"></div> | |