CLIENT REFERRAL FORM

(FOR PARTNER SERVICES)

Connecticut Department of Public Health

STD Control Program

Reset Form!

ATTN: _____ **Date:** _____

AGENCY/ORGANIZATION INFORMATION:

REFERRAL SITE (NAME): _____

PERSON REFERRING (NAME): _____

☐ **CRCS** ☐ **EIS** ☐ **ETI** ☐ **MCM** ☐ **OTL** ☐ **OTHER:** _____

PHONE NUMBER: _____ **E-MAIL:** _____

REASON FOR REFERRAL:

☐ Newly diagnosed HIV client, diagnosed within the last 12 months.

Client infected more than 12 months ago and:

☐ New reportable STD diagnosis, infected within the last 3 months.

☐ Unprotected sex within last 3 months with multiple partners and/or anonymous partner(s) and/or new partner(s).

☐ Known partners unaware of status, client is having sex after HIV diagnosis.

☐ Client is requesting partner services for a new partner.

☐ Client is diagnosed and incarcerated in Department of Corrections and was never interviewed for partners.

CLIENT INFORMATION:

Last Name: _____ First Name: _____ DOB: _____

Gender: ☐ Male ☐ Female ☐ Transgender Marital/Relationship Status: _____

Ethnicity: ☐H ☐NH Race: ☐AI/AK ☐Asian ☐Black/AA ☐Native HI/PI ☐White ☐D/K

Primary Language: _____

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone # (Home/Cell): _____

Websites/Phone Applications: _____ Screen Name: _____

E-mail Addresses: _____

Physical Description: _____

_____

_____

Diagnosis Date: _____ Previous Negative Date: _____

HIV Medical Care Physician's Name: _____ Phone #: _____

***DO NOT* E-MAIL THIS FORM!**

NOTE. **Please contact and speak directly to Terry Tierney at (860) 757-4848 or Wanda Richardson at (203) 946-7233 prior to sending any fax. Completed forms can be faxed to: Terry Tierney at 860-722-8132 or Wanda Richardson at 203-946-2950.**

Print Form