



Phone: 9076 3658 Fax: 9076 8819

Consultation Request Form

Source of Request

Name _____ Agency/Practice _____

Address _____

Phone _____ Mb _____

Fax _____ E-mail _____

Contact Days/Hours _____

Client Details

Name _____
(Surname) (Given Names)

Date of Birth _____ Sex Male Female

Address _____

Phone _____ Mb _____

Cultural background _____ Interpreter required Yes No

Client consent for consultation Written Verbal

GP _____ Agency/Practice _____

S100 Prescriber _____ Agency/Practice _____

Reason for consultation request (what question would you like addressed in the consultation)

Client Profile (living situation, employment, substance use, recent salient events, issues of confidentiality)

Medical History (include: medication side-effects, non-HIV health issues, psychiatric diagnoses)

Yr HIV Dx _____ Yr AIDS defining illness _____ (*please specify*) _____

CD4 _____ Date _____ Viral Load _____ Date _____

CD4 Nadir _____ Date _____

Current Medication _____

Main problem/treatment and progress to date (include previous treatments/interventions tried, adherence, emotional health, psychosocial supports):

Other support services involved

- Royal District Nursing Service **Contact** _____
- In home support **Contact** _____
- Positive Living Centre **Contact** _____
- Positive Counselling **Contact** _____
- VAC Counselling **Contact** _____
- Other please specify _____

Signature of referrer _____ **Date** _____

Office Use Only: Date request received: _____ Date presented at clinical review _____ Outcome: _____
--



CONSENT FOR RELEASE OF INFORMATION

I give permission to the Victorian HIV Consultancy to:

- Gather, share and discuss information relevant to my health status and social situation with the professionals involved in my care as listed (may include: GP, S100 prescriber, Consultant, hospital, nursing and social support services):

Name _____ of (agency name) _____

Name _____ of (agency name) _____

Name _____ of (agency name) _____

Name _____ of (agency name) _____

- read my Alfred Hospital file (if one available/applicable)

Client Name (please print) _____

Signed _____ Date _____

Witness (please print) _____

Signed _____ Date _____

In the absence of written consent by the client:

This client has provided verbal consent for the VHIVC to gather, share, and discuss information as documented above.

Practitioner Name (please print) _____

Signed _____ Date _____