Diagnosis Form

This form must be completed and signed by a licensed physician or other licensed healthcare provider. Physicians or healthcare providers are to complete this form to indicate that the patient below is living with HIV or AIDS.

Client/ Patient Information

Name (First, M.I., Last):____

Date of Birth:__________________________

Diagnosis Verification: Please select the box that applies and complete the section

Confirmatory HIV Positive Result: Complete below if the client has a confirmatory HIV Positive Result.

I____________________________________ (enter licensed physician or other licensed healthcare provider name) hereby certify the client/patient is living with HIV or AIDS. I hereby certify that the information provided is factual, accurate, and complete.

Pending HIV lab: Complete below if the client has a rapid test.

I____________________________________ (enter licensed physician or other licensed healthcare provider name) hereby certify the client/patient completed one positive rapid assay pending confirmatory HIV lab test (client will need to be placed on a 30-day Temporary Access Period by the ADAP Enrollment Worker and must provide confirmatory HIV lab within 30 days).

Diagnosis

HIV – Not AIDS AIDS – As defined by the CDC

Licensed Health Care Provider Information

Licensed Healthcare Provider Name:________________________________

Licensed Physician or Healthcare Provider Medical License Number:____________________

Hospital/ Clinic Name:______________________________________

Hospital/ Clinic Address:_____________________________________

Phone:______________________________Date:______________________________

Licensed Physician or Healthcare Provider Signature:__________________________