LINKAGE TO CARE REFERRAL FORM

FOR ARTAS INTERVENTION AND HIV MEDICAL CARE LINKAGE

PATIENT INFORMATION			
Last Name	First Name		Date
Street Address		Apartment/Unit #	
City	State GA	ZIP	
Phone	Alternate Phone		
Date of Birth	Race	Ethnicity	

EXAM INFORMATION			
Oraquick Exam Date	/ /	HIV Confirmatory Exam Date	/ /
HIV Elisa Exam Date	/ /	Last TB Exam Date	/ /
Last in HIV Medical Care (Previous +)	/ /	TB Exam Results	☐ Infectious ☐ Non-Infectious
Name of HIV Provider		Name of TB Provider	

COMMENTS (PLEASE INCLUDE ADDITIONAL CONTACT INFORMATION IF APPLICABLE)

Referral Source: ☐ STD Program ☐ TB Program ☐ Refugee Health Program ☐ Private Provider: _____

☐ CBO: _____ ☐ Other: _____ARCA_____

Please fax completed form to the Linkage to Care Program at (404) 508-7860.

LTC Program Outgoing Referrals:

Referred To: ☐ Ryan White ☐ Grady IDP ☐ Private Provider: _____ ☐ Support Services: _____