Medical Case Management Screening Tool

Please attach to client registration or reassessment form

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Today's Date:	Client URN:	Assigned Case Manager:
Last Name:	First Name:	Middle Name:

HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider? ☐ Yes ☐ No (provide referral) ☐ Just entering the care system (provide referral)

2. Date of last medical appointment? _____ Date of next medical appointment? _____

3. Does the client have a copy of current labs (maximum of 6 months from today's date)? ☐ Yes ☐ No

4. Please check all of the barriers to medical care that the client mentions:

☐ Just entering the care system	☐ Not ready to access care	☐ Afraid
☐ Homelessness	☐ Doesn't want to deal with it	☐ Feels fine/no symptoms
☐ Doesn't know where to go	☐ Couldn't get an appointment	☐ Drugs/Alcohol in the way
☐ Doesn't think it will help	☐ Clinic hours aren't convenient	☐ Child care unavailable
☐ Don't want people to know	☐ Doesn't like the doctors there	☐ No transportation
☐ Language barriers	☐ Lack of proper identification	☐ Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication? ☐ Yes ☐ No

2. Does the client currently take their medication? ☐ Yes ☐ No ☐ Sometimes

3. How many doses has the client missed in the last month? ☐ 0 ☐ 1 ☐ 2 or more

If client reports missing doses please ask them why, (check all that apply):

☐ Doesn't want to deal with it/take meds	☐ Lack of social support	☐ Medication regimen too complex
☐ Side effects	☐ Doesn't think meds work	☐ Alcohol and/or Drug Use/Abuse
☐ Depression/Mental Health issues	☐ Can't get refills in time	☐ Other:
☐ Too many pills	☐ Taste of medication	

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling? ❑ Yes ❑No ❑ Client Refused

If yes, where : _____

Notes:

NUTRITION SCREENING

1. What is your current weight and height? _____ feet _____ inches _____ weight

2. Without wanting to, have you experienced significant weight loss in the last 6 months? ☐ Yes ☐ No

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3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression? ☐ Yes ☐ No ☐ Other: _____

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)? ☐ Yes ☐ No

5. Do you have access to food? ☐ Yes ☐ No

Referral provided for Medical Nutrition Therapy or other food provider? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____
Notes:

CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?
☐ Yes (stop here) ☐ Never used either substance (stop here) ☐ No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener? ☐ Yes ☐ No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.
Referral provided for Substance or Alcohol abuse? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____
Notes:

EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL
Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?
❑ Yes (stop here) ❑No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see? ☐ Yes ☐ No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things? ❑ Yes ❑No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment? ❑ Yes ❑No ❑ Client Refused

If yes, where: _____
Notes: