Ohio Department of Health – HIV Care Services – Quality Management

Medical Provider Visit Form – 2009

Ohio Ryan White Part B Clinical Quality Improvement Program

Provider Name:

Practice Name:

Question		
1. Patient full name:		
2. SS#:	_____ – ____ – _____	
3. Date of birth (MM/DD/YYYY):	___ /___ /_____	
4. Date of first outpatient care visit at this clinical practice (MM/DD/YYYY):	___ /___ /_____	
5. Date of this visit and three most recent visits (MM/DD/YYYY):	___ /___ /_____ ___ /___ /_____	___ /___ /_____ ___ /___ /_____
6. Report all CD4 cell counts during 2009: (If more than 4, use the 4 most recent counts.)	Value_____ Date_____ Value_____ Date_____	Value_____ Date_____ Value_____ Date_____
7. Report all viral load counts during 2009: (If more than 4, use the 4 most recent counts.)	Value_____ Date_____ Value_____ Date_____	Value_____ Date_____ Value_____ Date_____
8. Was the patient prescribed or receiving PCP prophylaxis at any time during 2009?	❒ No ❒ Yes ❒ Not medically indicated ❒ No, client refused ❒ Unknown	
9. Was the patient prescribed or receiving HAART at any time during 2009?	❒ Yes ❒ No – not medically indicated ❒ No – not ready (as determined by clinician) ❒ No – client refused ❒ No – intolerance, side-effect, toxicity ❒ No – HAART payment assistance unavailable ❒ No – other ❒ Unknown	
10. Has the patient completed the vaccine series for Hepatitis B?	❒ No ❒ Yes ❒ Not medically indicated ❒ Unknown	

11. Indicate which of the following screenings have been completed for this patient:					
Screened for:	**At this visit?**	**Since testing HIV positive?**	**Not medically indicated?**	**Result?**	**Unknown**
HIV risk reduction counseling	❒No ❒Yes	❒No ❒Yes			❒Unknown
Substance use (alcohol /drugs)	❒No ❒Yes	❒No ❒Yes	❒NMI		❒Unknown
Mental health issues	❒No ❒Yes	❒No ❒Yes	❒NMI		❒Unknown
TB	❒No ❒Yes	❒No ❒Yes	❒NMI	❒Neg ❒Pos	❒Unknown
Syphilis	❒No ❒Yes	❒No ❒Yes	❒NMI	❒Neg ❒Pos	❒Unknown
Hepatitis B	❒No ❒Yes	❒No ❒Yes	❒NMI	❒Neg ❒Pos	❒Unknown
Hepatitis C	❒No ❒Yes	❒No ❒Yes	❒NMI	❒Neg ❒Pos	❒Unknown
If female: Pap	❒No ❒Yes	❒No ❒Yes	❒NMI	❒Normal ❒Abnormal	❒Unknown

Female patients only:	
12a. Was the patient pregnant at any time during 2009?	❒ No (skip 12b and 12c) ❒ Yes ❒ Unknown
12b. When did the patient enter prenatal care?	❒ 1st trimester ❒ 2nd trimester ❒ 3rd trimester ❒ At delivery ❒ Not applicable ❒ Unknown
12c. Was the patient prescribed antiretroviral therapy to prevent vertical transmission of HIV to the fetus?	❒ No ❒ Yes ❒ Not applicable ❒ Unknown

Please fax all completed forms to our secure fax using the following information:

Attention: Cassandra Rae Chronos, RN
Quality Improvement Coordinator
Quality Management – HIV Care Services – Ohio Department of Health
Fax: 866.448.6337
Email: cassandra.chronos@odh.ohio.gov