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Government of **Western Australia**

Department of **Health**

Public and Aboriginal Health Division

**Communicable Disease Control Directorate**

**REFERRAL TO**

**INTEGRATED CASE MANAGEMENT PROGRAM (ICMP)**

**ICMP case management officer contacts**:

**CMO 1: (08) 6372 5900 CMO 2: (08) 6372 5901 CMO 3: (08) 6372 5902**

**Email completed referrals to:** [CMP.Referrals@health.wa.gov.au](mailto:CMP.Referrals@health.wa.gov.au)

**Check relevant box below*:***

Concerns about HIV transmission to others through high viral load and/or poor adherence to ART, and/or high-risk sexual/injecting drug use behaviours

New or prior diagnosis and loss to follow up to HIV specialist care.

Poor medication adherence and/or sustained detectable viral load.

Requires some psychosocial support to remain adherent to treatment.

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| **REFERRER:** | | | | | | | | | | | | | | | |
| Agency/ referrer/ contact details | |  | | | | | | | | | | | | | |
| Date | |  | | | | | | | | | | | | | |
| Other relevant agency staff | |  | | | | | | | | | | | | | |
| **CLIENT DEMOGRAPHIC INFORMATION:** | | | | | | | | | | | | | | | |
| UMRN (If available) |  | | | | | | | | | | | | | | |
| SURNAME**:** |  | | | | | | | | | | | | | | |
| FIRST NAME: |  | | | | | | | | | | | | | | |
| Other names: |  | | | | | | | | | | | | | | |
| Aliases: |  | | | | | | | | | | | | | | |
| DOB: |  | | | | | | | Place of birth | |  | | | | | |
| Ethnicity |  | | | | | | | | | | | | | | |
| Interpreter required | Yes ☐ | | | No ☐ | Language | | | | | | | | | | |
| Address 1 |  | | | | | | | | | | | | | | |
| Address 2 |  | | | | | | | | | | | | | | |
| Phone numbers |  | | | | | | | | | | | | | | |
| Email: |  | | | | | | | | | | | | | | |
| Sexual orientation and gender identification | | | | | |  | | | | | | | | | |
| **CONTACTS:** | | | | | | | | | | | | | | | |
| NOK 1/ emergency contacts / relationship | | | | | | |  | | | | | | | | |
| NOK 2/ emergency contacts / relationship | | | | | | |  | | | | | | | | |
| Local contact 1 / relationship | | | | | | |  | | | | | | | | |
| Local contact 2 / relationship | | | | | | |  | | | | | | | | |
| If relevant, contact tracing commenced, by whom? | | | | | | |  | | | | | | | | |
| Who is aware of diagnosis? | | | | | | |  | | | | | | | | |
| Sexual contacts | | | | | | |  | | | | | | | | |
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| **MEDICAL INFORMATION:** | | | | | | | | | | | | | | | |
| HIV diagnosis date | | |  | | | | | | | | | | | | |
| HIV specialist provider | | |  | | | | | | | | | | | | |
| Last appointment attended | | |  | | | | | | | | | | | | |
| Treatment / medications / date | | |  | | | | | | | | | | | | |
| Last Viral Load result / date | | |  | | | | | | CD4 count / date | | |  | | | |
| Other positive STI results/ date | | |  | | | | | | | | | | | | |
| GP name/ contact | | |  | | | | | | | | | | | | |
| Other medical conditions, and treatment | | |  | | | | | | | | | | | | |
| **BACKGROUND INFORMATION FOR TRIAGING / RISK CONCERNS:** | | | | | | | | | | | | | | |
| Currently on ART or long-acting injectable treatment | | | | | | | | | | | Yes | | No | Unknown |
| Any challenges attending HIV related medical appointments and pathology, collecting medications | | | | | | | | | | | Yes | | No | Unknown |
| High risk sexual practices | | | | | | | | | | | Yes | | No | Unknown |
| Any treatment adherence concerns | | | | | | | | | | | Yes | | No | Unknown |
| Difficulties negotiating safe sex | | | | | | | | | | | Yes | | No | Unknown |
| Sex industry worker | | | | | | | | | | | Yes | | No | Unknown |
| Working name(s)/aliases: | | | | | | | | | | | | | | |
| Websites used to advertise: | | | | | | | | | | | | | | |
| Does client have a reasonable understanding of HIV, modes of transmission and prevention | | | | | | | | | | | Yes | | No | Unknown |
| Family / domestic violence victim or perpetrator | | | | | | | | | | | Yes | | No | Unknown |
| Child protection concerns | | | | | | | | | | | Yes | | No | Unknown |
| Risk of suicide / self-harm (previous attempts) | | | | | | | | | | | Yes | | No | Unknown |
| Homeless / transient: alternative addresses | | | | | | | | | | | Yes | | No | Unknown |
| Cognitive or other disability concerns | | | | | | | | | | | Yes | | No | Unknown |
| History of violence / aggression / staff safety concerns – Please note to whom: | | | | | | | | | | | Yes | | No | Unknown |
| Alcohol use | | | | | | | | | | | Yes | | No | Unknown |
| Injecting drug use | | | | | | | | | | | Yes | | No | Unknown |
| Illicit drug use; prescription misuse or solvent use: | | | | | | | | | | | Yes | | No | Unknown |
| Other risk concerns: Please note below. | | | | | | | | | | | Yes | | No | Unknown |
| **OTHER ISSUES:** | | | | | | | | | | | | | | |
| Literacy issues | | | | | | | | | | | Yes | | No | Unknown |
| Financial concerns | | | | | | | | | | | Yes | | No | Unknown |
| Visa status or concerns | | | | | | | | | | | Yes | | No | Unknown |
| **OTHER AGENCIES INVOLVED:** | | | | | | | | | | | | | | |
| WAAC | | | | | | | | | | | Yes | | No | Unknown |
| Magenta | | | | | | | | | | | Yes | | No | Unknown |
| Department of Communities (Housing) | | | | | | | | | | | Yes | | No | Unknown |
| Homeless / other housing | | | | | | | | | | | Yes | | No | Unknown |
| Justice / Prisons | | | | | | | | | | | Yes | | No | Unknown |
| Alcohol and drug agencies | | | | | | | | | | | Yes | | No | Unknown |
| Mental Health | | | | | | | | | | | Yes | | No | Unknown |
| Other | | | | | | | | | | | Yes | | No | Unknown |
| Public Health Units | | | | | | | | | | | Yes | | No | Unknown |
| **ADDITIONAL INFORMATION:** *Please attach any other relevant information* | | | | | | | | | | | | | | |
| ***(Please note any culturally relevant matters).*** | | | | | | | | | | | | | | |
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| Is client aware of referral? | | Yes | No | | Unknown | |
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| Client has consented to this referral? | | | | Yes | | No |
| Client signature | Date | | | | | |

(preferred, but not required)

|  |  |
| --- | --- |
| Referrer signature | Date |

(email is accepted as electronic signature)