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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

**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  |  |
|  |
| **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 [ ]  |
|  |
| Client has consented to this referral? | Yes [ ]  | No [ ]  |
| Client signature  | Date |

(preferred, but not required)

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

(email is accepted as electronic signature)