

Client Name: _____ Client Record #: _____

Enroll Date: _____ Patient Navigator: _____ Last PCP Visit Date: _____

Care Coordinator or Patient Navigator: Please discuss the client with the PCP and use this form to guide discussion at least once quarterly throughout the client's program enrollment.

Is this a formal/scheduled ongoing case review?

Yes No

Date of Care Team Meeting/Case Conference: _____

Previous Meeting	Current Meeting																								
(Date: _____)*	From EMR and program records																								
<table border="1"> <thead> <tr> <th></th> <th>#</th> <th>Date(s)</th> </tr> </thead> <tbody> <tr> <td>Previous CD4:</td> <td></td> <td></td> </tr> <tr> <td>Previous VL:</td> <td></td> <td></td> </tr> </tbody> </table>		#	Date(s)	Previous CD4:			Previous VL:			<table border="1"> <thead> <tr> <th></th> <th>#</th> <th>Date(s)</th> </tr> </thead> <tbody> <tr> <td>Most recent CD4:</td> <td></td> <td></td> </tr> <tr> <td>Most recent VL:</td> <td></td> <td></td> </tr> <tr> <td>Hospitalizations since last meeting*:</td> <td></td> <td></td> </tr> <tr> <td>ED visits since last meeting*:</td> <td></td> <td></td> </tr> </tbody> </table>		#	Date(s)	Most recent CD4:			Most recent VL:			Hospitalizations since last meeting*:			ED visits since last meeting*:		
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# of missed PCP appointments reported at last meeting: _____ N/A (no prior conference)	Missed PCP appointments reported at last meeting: _____																								
	Topics covered since last meeting*: _____																								
<i>*Refer to intake assessment, if this is the first Care Team meeting.</i>	Total # of topics covered to this point: _____																								

Progress Notes (Include progress with enrollment in services, topics covered, adherence barriers, risk behaviors, disclosure issues, social issues or services, and any other developments relevant to Care Plan):

ART Regimen Review Currently prescribed ART: YES NO *If No, skip to Notes on Page 3.*

Check the appropriate option:

Regimen unchanged since last case conference. *If checked, skip to Page 2.*

Regimen changed since last conference. *If checked, indicate reason for regimen change below.*

Reason for regimen change:

Treatment failure/viral resistance

Intolerance/side effects (Specify: _____)

Change in guidance/regimen simplification

Other (Specify: _____)

Current ART Medications:	Pills/dose	Dose Frequency	Continued or New?		If New, Start Date:
			Continuing	New	
			Continuing	New	
			Continuing	New	
			Continuing	New	

Adherence Review *Complete only if client is prescribed ART. Leave left side blank if this is the first Care Team meeting.*

Record Self-Report Adherence Assessment			
From Previous Conference:		For Current Conference:	
Date of last self-report Adherence Assessment at previous conf	Date	Date of most recent available self-report Adherence Assessment	Date
4-day self-report adherence value <i>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D</i>	Value	4-day self-report adherence value <i>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D</i>	Value
Last missed dose score <i>Value from 0-5, Adherence Assessment P. 2, Question 2</i>	Value	Last missed dose score <i>Value from 0-5, Adherence Assessment P. 2, Question 2</i>	Value
VAS adherence value <i>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a</i>	Value	VAS adherence value <i>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a</i>	Value



Client Name: _____

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Notes on Current Needs: Include adherence barriers, risk behaviors, disclosure issues, housing issues, social issues, and any other behavioral, clinical, or psychosocial concerns that need to be addressed

Notes on Case Conference Discussion:

Does Care Plan need to be updated? YES NO *If Yes*, Date Updated: _____

Client Disposition Summary

Discharge from program? Yes No

	Name	Signature	Date
Physician/PA/NP			
Care Coordinator			