

Dignity HMC Initial Request for Services

Client Name: _____ Date: _____
Date of Birth _____ SSN _____
Best phone number: _____ Permission to leave voicemail? Y N
Email address: _____ Permission to email? Y N
Emergency Contact Name, Relationship to you, and Phone: _____

Does DHMC staff have permission to contact your emergency contact? Yes No

1. Is English your primary language? Yes No
2. Are you newly diagnosed?
Yes No Date of Diagnosis _____ Previous Provider _____
3. Are you on HIV medications?
Yes No Name of Med _____
4. Are any of your medications new?
Yes No
5. If you are on meds, do you have **LESS** than a 30-day supply?
Yes No
6. To the best of your memory, when were your most recent labs completed?

7. Have you recently been hospitalized, incarcerated, or in any type of in-patient program?
Yes No
8. Do you have a stable housing situation?
Yes No If yes, what is the address? _____
9. Are you a veteran?
Yes No
10. IF FEMALE, are you pregnant or do you think you might be pregnant?
Yes No Unsure

Notes: _____

