Massachusetts HIV Drug Assistance Program (HDAP)
Clinician Form

This form must be completed by a clinician.

Patient Information

Full First Name:	Full Last Name:
HDAP ID (if known):	Date of Birth:
Patient's Clinical Status (must select one) ☐ HIV+, not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-defined AIDS Date of HIV Diagnosis (if known): Date of last negative HIV test (if known):	Patient's risk factors of exposure (check all that apply) ☐ Blood, blood products, tissue ☐ Hemophilia/coagulation disorder ☐ Heterosexual contact ☐ Man who has sex with men (MSM) ☐ Other risk (known but not listed) ☐ Perinatal transmission ☐ Person who injects drugs ☐ Undetermined/unknown

Patient's most recent lab results: Please provide the most recent viral load test result. For CD4, please provide nadir, or lowest CD4, and date of test. (NOTE: federal funding requires that we collect this information. If this section is left blank, patient can still enroll, but provider will be contacted to complete.)

Viral Load:_____ Date:_____

Nadir CD4:_____ Date:_____

Clinician Information

Institute/Facility:	
Name:	Department:
Street Address:	
City, State, ZIP:	Preferred contact: ☐ Phone calls ☐ Emails
Direct Phone:	Email:

Clinician Signature

By signing this form, I attest that the above individual has been diagnosed with HIV and is receiving care and/or services at my organization.

Clinician Signature: _____ **(MD, DO, PA, NP, RN)** Date:_____

Clinician Name (print): _____ Title: _____

Medical License Number: _____

Instructions:

- Return this to the client or case manager submitting the application. This form can be uploaded to the electronic application in the HDAP Client or Provider portals.
- Or you may fax this and any supporting documents to 617.502.1703.
- Or you can mail the completed form and any supporting documents to:

ATTN: HDAP
The Schrafft's City Center
529 Main Street, Suite 301
Boston, MA 02129

- For help with this application, please call HDAP at 800.228.2714.