

# Medical Case Management Screening Tool

Please attach to client registration or reassessment form



Today's Date:	Client URN:	Assigned Case Manager:
Last Name:	First Name:	Middle Name:

## HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider?  Yes  No (provide referral)  Just entering the care system (provide referral)
2. Date of last medical appointment? \_\_\_\_\_ Date of next medical appointment? \_\_\_\_\_

3. Does the client have a copy of current labs (maximum of 6 months from today's date)?  Yes  No

4. Please check all of the barriers to medical care that the client mentions:

<input type="checkbox"/> Just entering the care system	<input type="checkbox"/> Not ready to access care	<input type="checkbox"/> Afraid
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Doesn't want to deal with it	<input type="checkbox"/> Feels fine/no symptoms
<input type="checkbox"/> Doesn't know where to go	<input type="checkbox"/> Couldn't get an appointment	<input type="checkbox"/> Drugs/Alcohol in the way
<input type="checkbox"/> Doesn't think it will help	<input type="checkbox"/> Clinic hours aren't convenient	<input type="checkbox"/> Child care unavailable
<input type="checkbox"/> Don't want people to know	<input type="checkbox"/> Doesn't like the doctors there	<input type="checkbox"/> No transportation
<input type="checkbox"/> Language barriers	<input type="checkbox"/> Lack of proper identification	<input type="checkbox"/> Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

## HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication?  Yes  No
2. Does the client currently take their medication?  Yes  No  Sometimes
3. How many doses has the client missed in the last month?  0  1  2 or more
- If client reports missing doses please ask them why, (check all that apply):

<input type="checkbox"/> Doesn't want to deal with it/take meds	<input type="checkbox"/> Lack of social support	<input type="checkbox"/> Medication regimen too complex
<input type="checkbox"/> Side effects	<input type="checkbox"/> Doesn't think meds work	<input type="checkbox"/> Alcohol and/or Drug Use/Abuse
<input type="checkbox"/> Depression/Mental Health issues	<input type="checkbox"/> Can't get refills in time	<input type="checkbox"/> Other:
<input type="checkbox"/> Too many pills	<input type="checkbox"/> Taste of medication	

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling?  Yes  No  Client Refused

If yes, where : \_\_\_\_\_

Notes:

## NUTRITION SCREENING

1. What is your current weight and height? \_\_\_\_\_ feet \_\_\_\_\_ inches \_\_\_\_\_ weight
2. Without wanting to, have you experienced significant weight loss in the last 6 months?  Yes  No

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3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression?  Yes  No  Other: \_\_\_\_\_

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)?  Yes  No

5. Do you have access to food?  Yes  No

Referral provided for Medical Nutrition Therapy or other food provider?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes:

## CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?

Yes (stop here)  Never used either substance (stop here)  No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use?  Yes  No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use?  Yes  No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use?  Yes  No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener?  Yes  No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.

Referral provided for Substance or Alcohol abuse?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes:

## EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL

### Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?

Yes (stop here)  No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see?  Yes  No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless?  Yes  No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things?  Yes  No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes: