BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

HIV Drug Treatment Program
ENROLMENT FORM

Providence HEALTH CARE
How you want to be treated.

OFFICE USE ONLY
BC-CfE #

Completion of this form is required only ONCE for each patient at the time of **initial enrolment** in the HIV Drug Treatment Program.

Return completed form to the BC Centre for Excellence in HIV/AIDS:
By Mail: 608-1081 Burrard Street, Vancouver BC V6Z 1Y6 **By Fax:** 604-806-9044 **Telephone:** 604-806-8515

Please also complete the HIV PRESCRIPTION REQUEST form to request specific drug therapy, as required.

Enrolling Physician Information

First Name, Last Name	MSC #	Telephone
Address, City	Postal Code	Fax

If another physician will be authorizing prescription refills, please indicate in the Follow-up Physician section of Prescription Form

Patient Information

First Name(s)	Last Name	
Biological Sex ☐ Male ☐ Female	Transgendered ☐ M to F ☐ F to M	Date of Birth (DD/MON/YYYY) / /
BC Personal Health Number (PHN)	Other Health Plan Billing Number	Other Health Plan Name

First HIV Positive Date: DD_____ MON_____YYYY_____ (HIV serology date, or antigen date if age is 15 months or less)

Antiretroviral Treatment Status:

☐ Never Treated ☐ Previously Treated (but not currently taking medication) ☐ Currently Treated

AIDS Defining illness:

Has the patient ever experienced an AIDS defining illness, as defined by BC-CDC? (See pg. 2 on reverse, or www.bccdc.ca)

☐ Yes ☐ No ☐ Unknown If yes, date of initial event: MON_____ YYYY_____

Ethnicity:

a) Does this individual self-identify as an Aboriginal person, that is, First Nations, Métis or Inuit?

☐ Yes ☐ No ☐ Unknown

b) If the individual does not self-identify as an Aboriginal person, which ethnicity does this individual self-identify with?

☐ White ☐ Asian ☐ Hispanic ☐ Black

☐ Other: _____ ☐ Unknown

HIV Transmission Risk Factors (check all that apply)

☐ Sexual Exposure, Heterosexual ☐ Sexual Exposure, Same Sex Partner ☐ Sex Work

☐ Injection Drug Use ☐ Blood/Blood Product Recipient ☐ Perinatal (Mother to Child Transmission)

☐ Other Risk: _____ ☐ Unknown Risk

Enrolling Physician's Signature

Physician's Signature: _____ **Date:** DD_____ MON_____ YYYY_____

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AIDS Defining Illnesses (as defined by the BC CDC at www.bccdc.ca)

Bacterial pneumonia, recurrent
Candidiasis; Bronchi, trachea or lungs
Candidiasis; Esophageal
Cervical cancer, invasive
Coccidioidomycosis, disseminated or extrapulmonary
Cryptococcosis, extrapulmonary
Cryptosporidiosis (chronic intestinal >1 mo. duration)
Cytomegalovirus disease
Cytomegalovirus retinitis
Encephalopathy, HIV-related (dementia)
Herpes simplex (>1 mo. duration)
Histoplasmosis (disseminated or extrapulmonary)
Isoporiasis (>1 mo. duration)
Kaposi's sarcoma
Lymphoma, Burkitt's, immunoblastic
Lymphoma, primary in the brain
M. avium complex or M. kansasii
M. tuberculosis; disseminated or extrapulmonary
M. tuberculosis; pulmonary
Mycobacterium of other/unidentified species
Pneumocystis jiroveci (carinii) pneumonia
Progressive multifocal leukoencephalopathy
Toxoplasmosis of brain
HIV wasting syndrome (>10% body weight)

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