TARZANA TREATMENT CENTERS, INC.

CERTIFICATE OF ELIGIBILITY – PHYSICIAN

HIV Services

Patient's Name *(Print)*	**Date**
Social Security Number	**Date of Birth**

PHYSICIAN TO COMPLETE THIS PORTION

Diagnosis: □ HIV Asymptomatic □ HIV Symptomatic (Indicate all current symptoms below)

☐ AIDS (Indicate all current symptoms below)

Date of AIDS diagnosis _____ Date of AIDS Symptomatic diagnosis_____

Current HIV/AIDS symptoms include: _____

_____CD4 as of _____ _____ Viral load as of _____ Type of Test used _____

Opportunistic infections (Give dates): Has patient been screened for TB? ☐ Yes ☐ No

_____CD4 <200/14% TB Skin Test Date_____ Positive □ Negative □

_____KS TB Chest X-ray Date_____ Positive □ Negative □

_____PCP Is Patient currently receiving preventive TB treatment? ☐ Yes ☐ No

_____Other_____ Is Patient receiving treatment for Active TB? ☐ Yes ☐ No

COGNITIVE AND FUNCTIONAL ABILITY ASSESSMENT:

Stage I: 71 - 100	100	Normal, no complaints, no evidence of disease
	90	Able to carry on normal activity, minor signs or symptoms of disease
	80	Normal activity with effort, some signs or symptoms of disease
Stage II: 51 - 70	70	Cares for self. Unable to carry on normal activity or to do active work
	60	Requires occasional assistance; able to care for most of care needs
Stage III: 31 - 50	50	Requires considerable assistance and frequent medical care
	40	Disabled; requires special care and assistance
Stage IV: 0 - 30	30	Severely disabled, hospitalization is indicated. Death not imminent
	20	Very ill, active supportive treatment
	10	Moribund, fatal processes progressing rapidly
	0	Dead

What is the patient's actual Cognitive and Functional Ability Scale Score? _____

Does the patient meet the Nursing Facility Level of Care? ☐ Yes ☐ No

Dental: Is this patient medically able to receive routine dental care and/or oral procedures? ☐ Yes ☐ No

I am the Physician responsible for _____'s HIV care. I certify

Patient's Name (Print)

the above information is correct and based on a review of the patient's HIV treatment needs.

Physician's Signature _____ Date _____

Physician's Name *(Print)* _____ License # _____

Phone # _____

Address _____

FOR PROJECT USE ONLY:

Case Manager's Name _____ Phone# _____

Date Sent _____ Date Received _____