

Name:		Birth Date:	
Physical Street Address:			
Gender:	Race:	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	
Best Contact Phone Number:		Is this your phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Can we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Is it okay to text?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:			
Best time to contact you? <input type="checkbox"/> Daytime <input type="checkbox"/> Evening <input type="checkbox"/> Anytime <input type="checkbox"/> Specific Time:			
Diagnosis Date:		State diagnosed:	
Have you ever been prescribed Antiretroviral Therapy medication?		If "yes" what?	
Do you have an active Antiretroviral Therapy medication prescription?		If "yes" name of the last pharmacy that filled this prescription?	
Are you currently taking Antiretroviral Therapy medication? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "No" when was the last day you took the medication?			
If "Yes" how much medication do you currently have?			
Have you seen a doctor to treat your HIV in SD? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes" who is your current doctor?	
Have you been tested for other STIs in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "yes" what?			
Are you under 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever seen a doctor at the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you currently have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
By my signature, I authorize the South Dakota Department of Health to furnish Heartland Health Resource Center a copy of this referral form and any associated documents pertinent to the program. This authorization may be cancelled in writing at any time except to the extent that action has already been taken upon it. If not cancelled, this authorization will terminate in one year or upon the following specified date:			
Applicant Signature:		Date:	
Guardian Signature (If client is under 18):			
Primary language:			
Was an interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please Include any other relevant client information here:			