LINKAGE FOLLOW-UP FORM

REFERRING AGENCY: ______

Client Name: ________________(first)_________________(last)		Client Phone: _____-_____-______	Client URN: ________________
Referral Type Code ________________________		Date issued ____/____/____	
Receiving Agency Name Phone/FAX	______ Phone: ____-____-_____ Fax: ____-____-_____		

Follow-Up Attempts			
1st Attempt	Date ____/____/____ *(mm/dd/yyyy)*	Employee Name	If the referral is to HIV medical care has the client been on HAART within the last 6 months? _____Yes/ No_____
	Verify	Outcome Code	
2nd Attempt	Date ____/____/____ *(mm/dd/yyyy)*	Employee Name	If the referral is to HIV medical care has the client been on HAART within the last 6 months? _____Yes/ No_____
	Verify	Outcome Code	
3rd Attempt	Date ____/____/____ *(mm/dd/yyyy)*	Employee Name	If the referral is to HIV medical care has the client been on HAART within the last 6 months? ______Yes/ No_____
	Verify	Outcome Code	
Referral Closing	Date ____/____/____ ______________________ *(mm/dd/yyyy)* Outcome		

Verify Codes

Code	Type	Code	Type
01	HIV Testing	11	Substance Abuse Prevention and Treatment
02	HIV Confirmatory Testing	12	IDU Risk Reduction Services
03	HIV Prevention Counseling	13	Tuberculosis Testing
04	STD Screening & Treatment	14	Reproductive Health Services
05	Viral Hepatitis Screening and Treatment	15	Prenatal Care
06	Partner Services	16	General Medical Care
07	Mental Health Services	17	Housing Services
08	HIV Medical Care	18	Other prevention services
09	Comprehensive Risk Counseling Services (Risk Management)	19	Other (Specify)
10	Case Management		

Outcome Codes	
01	Pending
02	Completed
03	Lost to follow-up/referred to DIS
04	No follow-up

Consent to Follow up with Receiving Agency

I hereby consent to the release of appointment confirmation between:

____and
Referring Agency

____.
Receiving Agency

The only information to be shared is confirmation of the date that I came to the receiving agency in response to a referral. This information is confidential and is only to be used to improve, coordinate and evaluate the program. I understand that this consent is for a 90-day period from the date of my signature and I can revoke this consent at any time.

____ ______________________
Client Signature Date