COUNTY OF LOS ANGELES
Public Health
DIVISION OF HIV AND STD PROGRAMS

MEDICAL CARE COORDINATION (MCC) ASSESSMENT

Patient Last Name: _____ First Name:_____ Middle Initial:_____
Date of Birth: (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___
MRN:_____ ____ Casewatch ID#: _____
Date Assessment Started (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___
Date Assessment Completed (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___
Type of Assessment: Initial Assessment _____ Re-assessment:_____
MCM Last Name: _____ First Name:_____ Middle Initial:_____
PCM Last Name: _____ First Name:_____ Middle Initial:_____

***ALL INSTRUCTIONS FOR THE PCM AND MCM TO ADMINISTER THE MCC ASSESSMENT APPEAR IN CAPITOL, BOLD LETTERS– IF ADDITIONAL INSTRUCTION IS NEEDED, PLEASE REFER TO THE MCC ASSESSMENT GUIDANCE**

I. HEALTH STATUS

THE INFORMATION IN THE HEALTH STATUS SECTION SHOULD BE ABSTRACTED FROM THE PATIENT MEDICAL RECORD BEFORE COMPLETING THE ASSESSMENT WITH THE PATIENT

FOR PATIENTS WHO ARE NEWLY DIAGNOSED OR NEW TO THE CLINIC:
Is Health Status information currently available? ☐ *Yes* ☐ *No (if no, complete per the Guidance)*

1. Date diagnosed with HIV (mm/yyyy) : ___ ___/___ ___ ___ ___

2. Date of most recent CD4 count (mm/yyyy): ___ ___/___ ___ ___ ___ not available ☐
   Most recent CD4 count _____cells/mm^3

3. Date of most recent viral load (mm/yyyy): _____/_____ Most recent viral load _____copies/mL
   Was most recent viral load suppressed <200 copies/mL? ☐ No ☐ Yes Not available ☐

4. Does the patient have an AIDS diagnosis? ☐ No ☐ Yes
   Date of diagnosis (mm/dd/yyyy): ___ ___/___ ___/___ ___ ___ ___

5. What sex was patient assigned at birth? ☐ Male ☐ Female ☐ Intersex ☐ Don't know

6. FOR FEMALE PATENTS: Is patient currently pregnant? ☐ No ☐ Yes ☐ Unknown

7. PAST OR CURRENT MEDICAL CONDITIONS

7.1 HIV Related Complications or Conditions: check to indicate whether condition **ever occurred in the past** and if it **continues as an active (current) issue**

Check if **NO past or active** HIV related complications or conditions ☐ or if **UNKNOWN** ☐

CONDITION	PAST	ACTIVE	CONDITION	PAST	ACTIVE
AIDS Dementia	☐	☐	Histoplasmosis*	☐	☐
Bacterial pneumonia	☐	☐	HIV Nephropathy	☐	☐
Oral Candidiasis (Thrush)	☐	☐	Isosporiasis*	☐	☐
Candidiasis-Esophagus, Lungs*	☐	☐	Liver Disease (non Hep B or C)	☐	☐
Cervical Cancer , invasive*	☐	☐	Kaposi Sarcoma*	☐	☐
Coccidioidomycosis*	☐	☐	Lymphoma, Burkett's*	☐	☐
Cryptococcal infection*	☐	☐	Lymphoma, immunoblastic*	☐	☐
Cryptosporidiosis*	☐	☐	Mycobacterium Avium (MAC)	☐	☐
CMV of Liver, Spleen, Nodes only	☐	☐	Pneumocystis (PCP)	☐	☐
CMV Retinitis*	☐	☐	PML*	☐	☐
CMV-other *	☐	☐	Salmonella septicemia*	☐	☐
Hepatitis B, Chronic*	☐	☐	STDs	☐	☐
Hepatitis C, Chronic	☐	☐	Toxoplasmosis	☐	☐
Herpes Simplex- Chronic ulcers*	☐	☐	Mycobacterium Tuberculosis (TB)*	☐	☐
Herpes Simplex-Esophagus, Lungs*	☐	☐	Wasting syndrome due to HIV*	☐	☐
HIV-related Encephalopathy	☐	☐		☐	☐

*Indicates an AIDS-defining illness or Chronic Hep B

7.2 Chronic Disease Conditions: check to indicate if patient was **ever diagnosed** with condition and if the condition is **currently under poor control.**

Check here If **NO past or poorly controlled** chronic disease conditions ☐ or if **UNKNOWN** ☐

CONDITION	Ever diagnosed? YES	Under poor control? YES
Anemia	☐	☐
Asthma or Reactive Airways	☐	☐
Autoimmune Disease- **If yes**, what? _____	☐	☐
Cancer- **If yes**, what type? _____	☐	☐
Cerebrovascular Accident (CVA) or Stroke	☐	☐
Chronic kidney disease (CKD)- non-HIV related	☐	☐
Congestive heart failure (CHF)	☐	☐
Coronary artery disease (CAD) or heart attack	☐	☐
COPD or Emphysema	☐	☐
Dementia (non-HIV related)	☐	☐
Diabetes Mellitus (DM) Type I or II	☐	☐
Erectile dysfunction (ED)	☐	☐
Hyperlipidemia (HL) or high cholesterol	☐	☐
Hypertension (HTN) or high blood pressure	☐	☐
Lipodystrophy or changes in where you carry your body fat	☐	☐
Low testosterone or hypogonadism	☐	☐
Osteoporosis or hip or wrist fracture	☐	☐
Osteoarthritis (OA) **If yes**, where? _____	☐	☐
Vision problems (cataracts or other)	☐	☐

7.3 Neurologic/Mental Health: check to indicate whether condition **occurred in the past** and if it is an **active (current) issue**

Check here If **NO past or active** neurologic/mental health conditions ☐ or if **UNKNOWN** ☐

CONDITION	PAST	ACTIVE	CONDITION	PAST	ACTIVE
Anxiety	☐	☐	Neuropathy or painful burning or tingling	☐	☐
Bipolar disorder	☐	☐	Schizophrenia	☐	☐
Dementia/memory problems	☐	☐	Seizures	☐	☐
Depression	☐	☐	Other mental health issue_____	☐	☐

8. MEDICAL CO-MORBIDITIES

	NO	YES		NO	YES	DATE COMPLETED (mm/yyyy)
Ever diagnosed with Hepatitis B or C?	☐	☐→	**IF YES** - Did they complete treatment for Hepatitis B or C?	☐	☐	__ __/__ __ __ __
Ever vaccinated against Hepatitis A ?	☐	☐→	**IF YES** – Did they complete the series?	☐	☐	__ __/__ __ __ __
Ever vaccinated against Hepatitis B?	☐	☐→	**IF YES** – Did they complete the series?	☐	☐	__ __/__ __ __ __
Ever received a positive Tuberculosis (TB) test or told they were infected with TB?	☐↓	☐→	**IF YES**, did patient complete the recommended treatment?	☐	☐	__ __/__ __ __ __
	IF NO (no previous TB), provide date of most recent TB test:					__ __/__ __ __ __
	Result of most recent TB test: ☐ Positive ☐ Negative ☐ Indeterminate					

9. CURRENT MEDICATIONS

Were HIV medications prescribed to patient?

☐ No →***Skip to Q 9.2***

☐ Yes →***indicate specific HIV medications below***

Table 9.1. Record the list of **HIV medications** the patient is currently taking **(check all that apply)**:

Single-Tablet Regimens	**Filled?**	**Taking As Prescribed?**	**Any Side Effects?**	**Mark Any Side Effects**
☐ **Atripla** *efavirenz/emtricitabine/tenofovir DF (EFV/FTC/TDF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Complera** *Rilpivirine/emtricitabine/tenofovir DF (RPV/FTC/TDF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Stribild** *elvitagravir/cobicstat/emtricitabine/tenofovir DF (RPV/FTC/TDF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
NRTI/NtRTIs				
☐ **Combivir** *lamivudine/zidovudine (3TC/AZT)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Emtriva** *emtricitabine (FTC)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Epivir** *lamivudine (3TC)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Epzicom** *abacavir/lamivudine (ABC/3TC)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Retrovir** *zidovudine (AZT or ZDV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Trizivir** *abacavir/lamivudine/zidovudine (ABC/3TC/AZT)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Truveda** *emtricitabine/tenofovir DF (FTC/TDF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Videx EC** *didanosine (ddI)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Viread** *tenofovir dosoproxil fumarate (TDF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Zerit** *stavudine (d4T)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Ziagen** *abacavir sulfate (ABC)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash

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NNRTIs	**Filled?**	**Taking As Prescribed?**	**Any Side Effects?**	**Mark Any Side Effects**
☐ **Edurant** *rilpivirine hydrochloride (RPV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Intelence** *etravirine (ETV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Rescriptor** *delavirdine (DLV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Sustiva** *efavirenz (EFV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Viramune XR** *nevirapine (NVP)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
PIs				
☐ **Aptivus** *tipranavir (TPV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Crixivan** *indinavir (IDV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Invirase** *saquinavir (SQV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Kaletra** *lopinavir/ritonavir (LPV/r)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Lexiva** *fosamprenavir calcium (FPV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Norvir** *ritonavir (RTV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Prezista** *darunavir (DRV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Reyatez** *atazanavir sulfate (ATV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Viracept** *nelfinavir (NFV)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
INSTIs				
☐ **Isentress** *raltegravir (RAL)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Dolutegravir** *dolutgravir (DTG)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash Weight Loss
☐ **Elvitegravir** *elvitegravir (EVG)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash

Fusion/Entry Inhibitors	**Filled?**	**Taking As Prescribed?**	**Any Side Effects?**	**Mark Any Side Effects**
☐ **Fuzeon** *enfuvirtide, T-20 (ENF)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ **Selzentry** *maraviroc (MVC)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
PK Enhancers				
☐ **Cobicistat** *cobicistat (COBI)*	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
OTHER ARTs				
☐ Other 1: _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ Other 2: _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No	☐ Diarrhea ☐ Nausea ☐ Weight Gain ☐ Dizziness ☐ Neuropathy ☐ Weight Loss ☐ Fatigue ☐ Rash

9.2. Is the patient currently taking any mental health medication(s)?

☐ No

☐ Unknown

☐ Yes (list):_____

9.3. Record <u>any other medications</u> the patient is currently taking:

_____

_____

9.4. Is patient taking any <u>herbal or vitamin supplements</u>?

☐ No

☐ Unknown

☐ Yes* (list):_____

*Garlic, ginseng, melatonin, milk thistle, St. John's wort (Hypercin) or Valerian may interact with ARTs – discuss with patient if any of these are reported

10. Has patient been diagnosed with an STD in the last 6 months?

☐ No **(SKIP to Q11)**

☐ Yes (**IF YES,** complete table below):

STD TYPE	**DIAGNOSIS DATE (MM/DD/YYYY)**	**TREATED?**	
		NO	**YES**
Chlamydia	__ __/__ __/__ __ __ __	☐	☐
Gonorrhea	__ __/__ __/__ __ __ __	☐	☐
Herpes Simplex 1 or 2	__ __/__ __/__ __ __ __	☐	☐
Human Papillomavirus (HPV)	__ __/__ __/__ __ __ __	☐	☐
Trichomoniasis	__ __/__ __/__ __ __ __	☐	☐
Syphilis	__ __/__ __/__ __ __ __	☐	☐
Other: _____	__ __/__ __/__ __ __ __	☐	☐

11. VACCINATIONS

	NO	YES		DATE COMPLETED (MM/DD/YYYY)
Has patient ever received a pneumococcal (or pneumovax) vaccination?	☐	☐→	**IF YES**, date of most recent pneumovax vaccination	__ __/__ __/__ __ __ __
Has patient received an influenza vaccination or flu shot in the past 12 months?	☐	☐→	**IF YES,** –date of most recent influenza vaccination or flu shot	__ __/__ __/__ __ __ __

12. NUTRITION

Does the patient have any of the following "Severe Acuity" conditions?	**NO**	**YES**
1. Dramatic weight change (> 10% unintentional weight loss or gain) in previous 4-6 months	☐	☐
2. Gastrointestinal or oral problems that interfere with eating such as chronic oral or esophageal thrush, or dysphagia (chronic nausea/vomiting)	☐	☐
3. High risk comorbidity/ies such chronic kidney disease, dialysis, poorly-controlled diabetes mellitus or tube feedings	☐	☐
4. Complicated food-drug interactions	☐	☐

Does the patient have any of the following "High Acuity" conditions?	**NO**	**YES**
5. Newly diagnosed with HIV in the past 6 months	☐	☐
6. Comorbidity/ies such as DM, glucose intolerance, hypertension, liver disease, lipid abnormality, osteoporosis/osteopenia, anemia, or TB, that may be improved by nutrition counseling	☐	☐
7. Is obese or underweight, or has evidence of body fat redistribution (lipoatrophy or central adiposity)	☐	☐
8. CNS disease resulting in a decrease in functional capacity	☐	☐
9. Disordered eating such as anorexia, binging, purging, laxative/diet pill use, or a restrictive diet	☐	☐

II. QUALITY OF LIFE

(READ ALOUD TO PATIENT): I am going to ask you some questions about how you may feel and how well you are able to do your usual activities. It is not specific to HIV or AIDS. For each question, please give one answer that comes closest to the way you have been feeling.

1. In the past month, would you say your general health is excellent, very good, good, fair, or poor?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. Do you have any particular health concerns today?
   - ☐ No
   - ☐ Yes (describe :_____)

   2a. Would you like assistance talking to your doctor about your concerns? ☐ Yes ☐ No

INSTRUCTIONS: PLEASE READ AND CHECK IF PATIENT NEEDS HELP WITH ANY TASK AND COUNT THE NUMBER OF 'YES' RESPONSES TO SCORE

(READ ALOUD TO PATIENT): Right now, do you need help performing the following tasks?

Task	No	Yes	If YES, who helps?
3a. Feeding yourself	☐	☐	
3b. Getting from bed to a chair	☐	☐	
3c. Getting to the toilet	☐	☐	
3d. Getting dressed	☐	☐	
3e. Bathing or showering	☐	☐	
3f. Walking across the room -Do you use a cane, walker, or wheelchair?	☐	☐	If yes, specify cane, walker or wheelchair: _____
3g. Using the telephone	☐	☐	
3h. Taking your medicines	☐	☐	
3i. Preparing meals	☐	☐	
3j Managing money (like keeping track of expenses or paying bills)	☐	☐	
3k. Moderately strenuous housework, such as doing laundry	☐	☐	
3l. Shopping for groceries or personal items	☐	☐	
3m. Climbing a flight of stairs	☐	☐	
3o. Driving	☐	☐	
3p Getting to places beyond walking distance (like by bus or car)	☐	☐	
COUNT YES answers to get ADL SCORE			

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*****IF PATIENT IS OVER 50 YEARS OLD, ASK THE FOLLOWING QUESTIONS, OTHERWISE SKIP to NEXT SECTION*****

(READ EACH ITEM ALOUD): In the last 12 months have you:	No	Yes	Refused/ Don't know
4. Had more trouble than in the past with memory for day-to-day happenings, such as remembering where you put things, recalling recent events, remembering plans, appointments or phone calls?	☐	☐*	☐
5. Fallen 2 or more times?	☐	☐	☐
6. Fallen and hurt yourself or needed to see a doctor because of the fall?	☐	☐	☐
7. Been afraid that you would fall because of balance or walking problems?	☐	☐	☐
8. Had a problem with urinary incontinence (or your bladder) that is bothersome enough that you would like to know more about how it could be treated?	☐	☐	☐
9. Had problems with your vision or noticed a change in your vision?	☐	☐	☐
10. Had difficulty hearing?	☐	☐	☐

***IF YES to this item, further assessment with the MOCA test is needed**

III. ANTIRETROVIRAL ACCESS AND ADHERENCE

IF PATIENT IS NOT CURRENTLY ON ART THEN CHECK HERE ☐ AND SKIP TO NEXT SECTION

(READ ALOUD): Now I am going to ask you some questions about HIV, the medicine you take for your HIV and the ways that you take your HIV medicine. First, we would like to know if patients are familiar with two HIV terms: a CD4 count and a viral load. Would you mind if I ask you a few questions about that?

SCORE

1. Can you tell me what a CD4 count is? [did patient answer correctly? ☐ No ☐ Yes]

IF PATIENT ANSWERS CORRECTLY, ASK:

1a. Is the goal of treatment to make the CD4 count go up or down?

[1] Up [0] Down →ENTER SCORE→ ____

2. Can you tell me what a viral load count is? [Did patient answer correctly? ☐ No ☐ Yes]

IF PATIENT ANSWERS CORRECTLY, ASK:

2a. Is the goal of treatment to make the viral load go up or down?

[1] Down [0] Up →ENTER SCORE→ ____

3. What medicines are you currently taking to treat HIV? (**RESPONDENT MUST NAME ALL MEDICATIONS TAKEN IN TABLE 7.1 in the HEALTH ASSESSMENT SECTION)**

[1] Correct [0] Incorrect [0] Don't know →ENTER SCORE→ ____

Sum 1-3 to get HIV Literacy (HL) Score ____

4. Many patients find it difficult to take all their HIV medications exactly as prescribed. How many doses of your HIV medications did you miss in the last 7 days? (Number of doses)

☐0 doses ☐1 doses ☐2 doses ☐3 doses ☐4 doses

☐5 doses ☐6 doses ☐7 doses ☐8 or more doses

5. Please point to the place on the line on this card at the point that shows your best guess about how much of your prescribed HIV medications you have taken in the last month. We would be surprised if it were 100% for most people. [**SHOW PATIENT CARD A AND MARK POINT INDICATED USING LINE BELOW**]

Example: 0% means you have taken no HIV medication
50% means you have taken half of your HIV medication
100% means you have taken every single dose of your HIV medication.

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Do you ever forget to take your HIV medications? ☐ No ☐ Yes

7. If you are feeling worse, do you sometimes stop taking your HIV medications? ☐ No ☐ Yes

8. Did you miss taking any of your HIV medications over the past weekend? ☐ No ☐ Yes

9. Can you tell me some of the reasons it might be difficult to take your HIV medications regularly?
(Check all that apply):

✓		✓	
	You felt depressed or overwhelmed		Taking the drug would remind you of your HIV
	You were busy with other things or simply forgot		You were using alcohol and/or drugs
	You ran out of medication		You didn't think the drug was improving your health
	You were away from home		You were asleep when a dose was due
	You had too many pills to take		You wanted to make the medication last longer
	You were confused about dosing directions		You didn't want others to see you taking your medication
	The medications made you feel sick		Other reason:_____
	There was a change in your daily routine		N/A – not difficult to take medications

10. Does anyone help you remember to take your HIV medication? (**Check all that apply**)

- ☐ No - I do it myself
- ☐ Clinic staff
- ☐ Family
- ☐ Member of your congregation
- ☐ Friends
- ☐ Pharmacy pager
- ☐ Social worker or case manager
- ☐ Other: (Specify: _____

11. Does anyone get or pick-up your HIV medication for you (from the pharmacy)? (**Check all that apply**)

- ☐ No - I do it myself
- ☐ Clinic staff
- ☐ Family
- ☐ Member of your congregation
- ☐ Friends
- ☐ Pharmacy pager
- ☐ Social worker or case manager
- ☐ Other: (Specify: _____
- ☐ Pharmacy delivers

12. Do you ever have trouble getting your HIV medications?

☐ No ☐ Yes (describe):_____

IV. MEDICAL ACCESS, LINKAGE AND RETENTION

(READ ALOUD): Now I am going to ask you some questions about the doctors you see for medical care and things that may influence how you get to your HIV doctor appointments.

1. Do you have a doctor who you see regularly for your HIV care? ☐ No ☐ Yes

   If **NO**→ Provide a referral to doctor at the HIV medical home

   If **YES** → When was the last time you saw your HIV doctor? ___ ___/___ ___ ___ ___ ___ (mm/yyyy)

2. Do you have a dentist who you see regularly? ☐ No ☐ Yes

   If **NO**→ It is recommended that you see a dentist every 6 months, do you need a referral to a dentist? ☐ No ☐ Yes

   If **YES**→ When was the last time you saw your dentist? ___ ___/___ ___ ___ ___ ___ (mm/yyyy)

3. Do you have an eye doctor (an ophthalmologist) who you see regularly? ☐ No ☐ Yes

   If **NO**→ Do you need a referral for an eye doctor (ophthalmologist)? ☐ No ☐ Yes

   If **YES**→ When was the last time you saw your eye doctor? ___ ___/___ ___ ___ ___ ___ (mm/yyyy)

4. Do you have a doctor or provider who you see regularly for your mental health? ☐ No ☐ Yes

   If **NO**→ Do you need a referral for a mental health provider? ☐ No ☐ Yes

   If **YES**→ When was the last time you saw your mental health provider?

   ___ ___/___ ___ ___ ___ ___ (mm/yyyy)

5. Have you been hospitalized in the past 6 months? ☐ No ☐ Yes

   If **YES**→ What was/were the reason(s) you were hospitalized?

   Describe: _____

6. Have you been to the emergency room in the past 6 month? ☐ No ☐ Yes

   If **YES**→ What was/were the reason(s) you went to the emergency room?

   Describe: _____

7. Do you ever miss appointments with your doctor for your HIV care?

   ☐ No → SKIP to Q. 9

   ☐ Yes → How often do you miss your appointments?

   ☐ Very rarely

   ☐ Sometimes

   ☐ Usually or most of the time

   ☐ Always

(READ ALOUD): Some people find it difficult to attend their HIV medical appointments. What are some reasons it is hard for you to come to your HIV medical appointments?

8. Reason for missing appointments or falling out of care (do not read; check all that apply):

- ☐ 1. Felt good
- ☐ 2. Felt sick
- ☐ 3. Forgot to go
- ☐ 4. Was drinking or using drugs
- ☐ 5. Worried someone would find out about my illness
- ☐ 6. Didn't want to think about being HIV positive
- ☐ 7. Didn't believe HIV positive test result
- ☐ 8. Missed appointment
- ☐ 9. Had other responsibilities (child care/work)
- ☐ 10. Language barrier
- ☐ 11. Moved or out of town
- ☐ 12.Concern about immigration
- ☐ 13. Living back and forth between US and other country
- ☐ 14. Was homeless
- ☐ 15. Medical facility was inconvenient (location/hours/wait-time)
- ☐ 16. Couldn't find the right HIV health care provider
- ☐ 17. Disrespect or mistreatment from providers/clinic staff
- ☐ 18. Didn't have enough money or health insurance
- ☐ 19. Unable to get transportation
- ☐ 20. Unable to get earlier appointment
- ☐ 21. I didn't complete application process
- ☐ 22. Not eligible/denied
- ☐ 23.The system was too confusing
- ☐ 24.It wasn't available in my area
- ☐ 25.The wait list was too long

Which was the main reason that you missed appointments? (write the # of only one): _____

9. Does anyone remind you to go to your appointments for your HIV care? *[Check all that apply.]*

- ☐ No – I do it myself
- ☐ Family, spouse, or partner
- ☐ Friends
- ☐ Social worker or case manager
- ☐ Clinic staff/reminder call
- ☐ Member of your congregation
- ☐ Other: *(Specify:_____)*

V. HOUSING

INSTRUCTIONS: USE REGISTRATION FORM AS NEEDED FOR ADDITIONAL HOUSING INFORMATION

(READ ALOUD): "I am going to now ask you some questions about your living situation such as where you live and who may live with you."

(Check all that apply):

1. Where are you currently living?

- ☐ Rental unit alone
- ☐ Own home
- ☐ Live with friend (pay rent)
- ☐ Live with family
- ☐ Live with partner

[any of the above are STABLE – go to Q1a]

- ☐ Group or foster home
- ☐ Supportive housing
- ☐ Transitional
- ☐ Hotel/Motel/SRO
- ☐ Temporary (friend –do not pay rent)

[any of the above are TEMPORARY – go to Q2a]

- ☐ Car
- ☐ Outside/street
- ☐ Shelter
- ☐ Abandoned/vacant building
- ☐ Other:_____

[any of the above are HOMELESS – go to Q3a]

1a. Have you been homeless in the past 6 months? ☐ No ☐ Yes

1b. Have you received an eviction notice or had your utilities cut off in the past 6 months? ☐ No ☐ Yes

1c. Do you feel safe where you live?

☐ Yes

☐ No (WHY: ☐ Violence ☐ Not clean ☐ Other:_____

1d. Do you need help changing your housing situation? ☐ No ☐ Yes

2a. Have you been homeless in the past 6 months? ☐ No ☐ Yes

2b. Have you received an eviction notice or had your utilities cut off in the past 6 months? ☐ No ☐ Yes

2c. Do you feel safe where you live?

☐ Yes

☐ No (WHY: ☐ Violence ☐ Not clean ☐ Other:_____

2d. Do you need help changing your housing situation? ☐ No ☐ Yes

3a. How long have you been homeless? _____weeks

3b. Where do you: Sleep?_____

Eat (food lines)?_____

Hang out?_____

3c. Do you feel safe where you live?

☐ Yes

☐ No (WHY: ☐ Violence ☐ Not clean ☐ Other:_____

3d. Do you need help changing your housing situation? ☐ No ☐ Yes

VI. FINANCIAL

INSTRUCTIONS: USE THE REGISTRATION/SCREENING FORM AS NEEDED TO PROVIDE SPECIFIC FINANCIAL INFORMATION (HOUSEHOLD INCOME, HOUSEHOLD SIZE, DEPENDENTS, AND INCOME SOURCES)

(READ ALOUD): Now I am going to ask you some questions about your sources of money.

1. Do you have a monthly income? ☐ Yes ☐ No ☐ Refused
2. Is your monthly income source dependable? ☐ Yes ☐ No ☐ Don't know
3. Are you able to meet your monthly living expenses? ☐ Yes ☐ No ☐ Don't know

VII. TRANSPORTATION

(READ ALOUD): These next questions are going to ask about how you get to [NAME OF THIS HIV CLINIC]:

1. How much time does it usually take you to get to [NAME OF THIS HIV CLINIC]?
   _____ ***(circle one: Hours Minutes)***

2. How do you usually get to [NAME OF THIS HIV CLINIC? ***[Check all that apply. Don't read choices.]***

   ☐ Drive self
   ☐ Bus or metro
   ☐ Get driven by someone else
   ☐ Taxi
   ☐ Walk
   ☐ Other ***(Specify: _____)***

3. Is your source of transportation reliable? That is, you know you can use it when you need to.

   ☐ Yes
   ☐ No

4. How often do you ever miss your HIV doctor appointments because you do not have transportation?

   ☐ Usually or often
   ☐ Sometimes
   ☐ Rarely

VIII. LEGAL/END OF LIFE NEEDS

(READ ALOUD): Now I am going to ask you some questions about any legal needs that you might have. First I am going to ask some questions about any past incarceration.

1. Have you ever been incarcerated?

☐ No **If NO, skip to Question 2**

☐ Yes

☐ Refused **If REFUSED, skip to Question 2**

1a. Were you incarcerated in the past 6 months? ☐ No ☐ Yes ☐ Refused to answer

1b. Were you in jail? ☐ No ☐ Yes [IF YES, where: _____]

1c. Were you in prison? ☐ No ☐ Yes [IF YES, where: _____]

1d. For how long were you incarcerated? **(If more than once, length of last incarceration)**

☐ Less than 2 weeks ☐ More than 2 weeks but less than a year

☐ 1 to 2 years ☐ More than 2 years ☐ Refused to answer

1e. Are you currently on: ☐ Parole ☐ Probation

Okay to contact your parole/probation officer? ☐ No ☐ Yes

Probation officer: _____ Phone: (_____) _____

(READ ALOUD): We recommend that everyone, regardless of their health, tell us about how they would want their care handled if they are unable to make decisions for themselves.

2. Do you have any of the following? (**READ ALOUD and check all that apply**)

☐ Power of attorney ☐ Living will ☐ Will ☐ Refused to answer

☐ Health care proxy ☐ Guardianship ☐ Advanced directive (DNR or POLST form)

☐ Do not have any of these ☐ Other: _____

3. Do you need assistance with any of items that I just read? **(CHECK ALL THAT APPLY):**

☐ Power of attorney ☐ Living will ☐ Will ☐ Refused to answer

☐ Health care proxy ☐ Guardianship ☐ Advanced directive (DNR or POLST form)

☐ Do not have any of these ☐ Other: _____

4. Who should speak for you if you are unable to make health decisions?

Name: _____ Relationship: _____ Phone #:_____

IX. SUPPORT SYSTEM AND RELATIONSHIPS

(READ ALOUD): I am going to now ask you some questions about your relationships with the people in your life.

1. What is your current relationship status? Are you (read choices..)?

- ☐ Single, never married
- ☐ Divorced
- ☐ Widowed
- ☐ Married
- ☐ Engaged
- ☐ Partnered
- ☐ Other _____

(READ ALOUD) Now I am going to ask you some questions about the people in your life who may be helpful to you.

2. What types of people in your life who give you support such as advice, are there for you to talk to when you need it, or show you that they care about you? **(check all that apply – read if necessary to prompt patient)**

- ☐ Friend(s)
- ☐ Parents
- ☐ Other family member(s)
- ☐ Partner/Spouse
- ☐ Roommate
- ☐ Religious congregation members
- ☐ Don't have any
- ☐ Don't know/Refused to answer
- ☐ Other _____

3. What types of people in your life who causes you distress? This might be acting angry or unpleasant towards you, being critical of your lifestyle or making your life difficult. **(check all that apply – read if necessary to prompt patient)**

- ☐ Friend(s)
- ☐ Religious congregation members
- ☐ Parents
- ☐ Don't have any
- ☐ Other family member(s)
- ☐ Don't know/Refused to answer
- ☐ Partner/Spouse
- ☐ Other _____
- ☐ Roommate

4. To how many people have you disclosed your HIV status? _____ people

5. Whom have you disclosed your HIV status to? **(check all that apply – read aloud if necessary to prompt patient)**

- ☐ Friend(s)
- ☐ Religious congregation members
- ☐ Parents
- ☐ Don't have any
- ☐ Other family member(s)
- ☐ Don't know/Refused to answer
- ☐ Partner/Spouse
- ☐ Other _____
- ☐ Roommate

6. Would you like help telling anyone about your HIV status? ☐ No ☐ Yes ☐ Don't know

(READ ALOUD): Now I am going to ask you some questions about specific ways people in your life may or may not support you. Please tell me how often you get different types of support by saying none of the time, a little of the time, some of the time or most of the time. [SHOW CARD WITH RESPONSES]

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
7a. Do you have someone you can count on to listen to you when you need to talk?	1	2	3	4	5
7b. Do you have someone to take you to the doctor if you needed it?	1	2	3	4	5
7c. Do you have someone to give you information to help you understand a situation?	1	2	3	4	5
7d. Do you have someone whose advice you really want?	1	2	3	4	5
7e. Do you have someone who understands your problems?	1	2	3	4	5
Sum of each column for social support (SS) score					

INTERPERSONAL VIOLENCE

(READ ALOUD): Because violence is so common, I ask all my patients about their experiences with personal violence. Before I ask you about any experiences with personal violence, I want to let you know that I am will not share your health information with anyone except for in two situations. The first situation is if you tell me about harming yourself or others and the second, is if you tell me about abuse or neglect of a child or dependent adult. I am required to report these situations to the proper authorities and these are the two exceptions to my keeping your health information confidential. Do you have any questions for me about this?

8. Have you ever been a victim of domestic violence? ☐ No

☐ Yes – when was most recent episode (mm/yyyy):_____

Describe: _____

☐ Refused

[ANY RESPONSE IS YES and within past 3 months =POSSIBLE ONGOING VIOLENCE – PATIENT HAS SEVERE NEED, DOCUMENT AND SEEK CONSULTATION WITH CLINIC SUPERVISOR IMMEDIATELY]

Okay, can you please tell me if the following three statements are true or false?

9. Within the past month, has anyone threatened you with a weapon? ☐ Yes ☐ No ☐ Refused

10. Within the past month, have you been beaten so badly that you had to seek medical help? ☐ Yes ☐ No ☐ Refused

11. Within the past month, has anyone acted like he/she would like to kill you? ☐ Yes ☐ No ☐ Refused

12. How often do you feel that someone has no respect for your feelings? Would you say never, rarely, occasionally, often or always?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always

[ANY RESPONSE IS TRUE, OCCASIONALLY, OFTEN OR ALWAYS=POSSIBLE ONGOING VIOLENCE AND PATIENT HAS SEVERE NEED, DOCUMENT AND SEEK CONSULTATION WITH CLINIC SUPERVISOR IMMEDIATELY]

13. Do you have any dependents? ☐ No – SKIP TO Q15 ☐ Yes – if YES, complete table below

13a. Who are the dependents and how old are they? (Prompt for each column)

First Name of Dependent and Relationship	Age	Tested for HIV?	Dependent's HIV Status?	Aware of Patient's HIV Status?	Living with Patient?
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐
		Yes ☐ No ☐ DK ☐	HIV + ☐ HIV - ☐ DK ☐	Yes ☐ No ☐ DK ☐	Yes ☐ No ☐

14. Do you think that your dependents or other family members might need services related to HIV or other issues?

☐ No
☐ Yes If YES, describe. ____

SPIRITUALITY

15. When you have problems or difficulties in your family, work or personal life, do you ever seek comfort through religious or spiritual means, such as praying, meditating, attending a religious or spiritual service, or talking to a religious or spiritual advisor?

☐ No

☐ Yes

☐ Refused

16. Are there any issues related to your cultural/spiritual/religious beliefs that prevent you from accessing HIV medical or supportive services or taking your HIV medications?

☐ No

☐ Yes: (describe:____)

X. RISK BEHAVIORS

(READ ALOUD): Now I am going to ask you some questions about sex and HIV. Some of these questions may make some people uncomfortable but please try to answer them as honestly as you can I will not share your answers with anyone.

1. During the past 6 months have you had vaginal or anal sex with a partner?	No □ (**SKIP TO Q5**) Yes □
2. During the past 6 months, how many different partners have you had vaginal or anal sex with?	__ __ __
3. How many of those partners did you NOT use a condom with?	__ __ __ (**if 0 SKIP to Q4**)
3a. Did you ask all of them their HIV status?	No □ Yes □
3b. Did you tell all of them your HIV status?	No □ Yes □
4. Did you have sex with any of these ____ **(# from Q2**) partners in exchange for things like money, drugs, food, shelter or transportation?	No □ Yes □

5. Do you have a primary sex partner (e.g., girlfriend/boyfriend, wife/husband, significant other)?

☐ Yes

☐ No (**If NO, skip to Q6**)

5a. Does your main sex partner know your HIV status?

☐ Yes (**If YES, skip to Q6**)

☐ No

IF NO, 5a1. Would you like help telling them about your HIV status?

☐ **Yes**

☐ **No**

☐ **Don't know**

IF NO, 5a2. Why have you not disclosed your HIV status to them? (check all that apply)

☐ Client already told partner (Partner Services Used? (☐Yes ☐No)

☐ Patient will tell partner without assistance/planning

☐ Danger of domestic violence/intimate partner violence

☐ Patient will use INSPOT

☐ Partner abandonment issues

☐ Partner is deceased

☐ Confidentiality issues (discrimination, being found out, etc.)

☐ Barriers or clean injection equipment used

☐ Patient states it's not his/her responsibility

☐ Declined/Don't know

☐ Other (_____)

6. Have you ever been referred or used Partner Services (PS)? ☐ No → If no, SKIP

☐ Yes→ If so when? _____

6a. What disclosure options did you choose at that time?

☐ Self-Plan made with client # of Partners: _____

☐ Dual # of Partners: _____

☐ Anonymous Third Party # of Partners: _____

☐ **Other Partners not referred # of Partners: _____

Total number of Partners: _____

7. Your past sex partners could be at high risk for HIV or STDs. Would you like help telling any of your past sexual partners about your HIV status? We can help you do this anonymously (without giving your name), if you are interested.

☐ Yes, interested

☐ No, not interested

XI. ALCOHOL/DRUG USE AND ADDICTION

(READ ALOUD): Now I am going to ask you some questions about drugs and alcohol. Just like in the last section, some of these questions may make some people uncomfortable but please try to answer them as honestly as you can.

1. Have you ever used drugs or alcohol?

☐ Yes

☐ No **If NO, Skip to NEXT SECTION**

1a. Have you ever used any injection drugs?

☐ Yes

☐ No

1b. Have you used drugs or alcohol in the past 6 months

☐ Yes

☐ No **If NO, Skip to Q25**

1c. Have you used any injection drugs in the past 6 months?

☐ Yes

☐ No

INSTRUCTIONS (READ): Can you please tell me what types of drugs you have used in the past 6 months (**read each type aloud and then check patient's responses below**)

Drug Type	Yes	No
2. Alcohol	☐	☐
3. Marijuana/hashish	☐	☐
4. Hallucinogens/LSD/PCP/Psychedelics/Mushrooms	☐	☐
5. Inhalants	☐	☐
6. Crack/freebase	☐	☐
7. Heroin and cocaine (speedball)	☐	☐
8. Cocaine	☐	☐
9. Heroin	☐	☐
10. Street methadone (non-prescription)	☐	☐
11. Other opiates/opium/morphine/Demoral	☐	☐
12. Methamphetamines	☐	☐
13. Amphetamines (other uppers)	☐	☐
14. Tranquilizers /Barbiturates/Sedatives/downers	☐	☐
15. Other (specify):_____	☐	☐

(READ ALOUD): Now I am going to ask you some questions about the way you may have used drugs or alcohol in the past 6 months. As I mentioned before, some of these questions may make some people uncomfortable but please try to answer them the best that you can (circle patient response).

Substance abuse screener	**YES**	**NO**
16. Did you use larger amounts of drugs or alcohol or use them for a longer time than you planned or intended?	1	0
17. Have you tried to cut down on your drug or alcohol use but were unable to?	1	0
18. Did you spend a lot of time getting drugs or alcohol, using them, or recovering from using them?	1	0
19. Did you get so high or sick from drugs or alcohol that it kept you from doing work, going to school or caring for children or caused an accident or put you or others in danger?	2	0
20. Did you spend less time at work, school, or with friends so that you could use drugs or alcohol?	1	0
21. Did your drug or alcohol use cause emotional or psychological problems, problems with family, friends, work, or police, or any physical health or medical problems	3	0
22. Did you increase the amount of a drug or alcohol that you were using so that you could get the same effects as before?	1	0
23. Did you ever need to use a drug or alcohol to avoid withdrawal symptoms or keep from getting sick?	1	0
24. Did you get sick or have withdrawals when you quit or missed using a drug or alcohol?	1	0
ADD "YES" COLUMN (SA score≥ 3 indicates serious drug/alcohol problem)		

25. Are you currently trying to reduce or stop your drug or alcohol use?
    - ☐ No
    - ☐ Yes

26. Would you like to get help to reduce/stop your drug or alcohol use?
    - ☐ No
    - ☐ Yes
    - ☐ I don't know

27. Have you ever been in a treatment program for drug or alcohol use?
    - ☐ No
    - ☐ Yes (If yes, when (mm/yyyy): _____)

28. Are you currently in a drug or alcohol support group like Alcoholics Anonymous or Narcotics Anonymous?
    - ☐ No
    - ☐ Yes

XII. MENTAL HEALTH

(READ ALOUD): As part of the assessment, I ask all patients about their mental health and any counseling or mental health services they may have received. Again, you don't have to answer any questions you feel are too personal.

1. Have you ever experienced or been diagnosed with a mental or emotional illness or problem that got in the way of your daily routine or the usual things that you do?

☐ Yes

☐ No → **Skip to Q 2**

☐ Refused

1a. If yes, please indicate emotional illness/problem:

✓		✓	
	Adjustment disorder		Obsessive-compulsive disorder
	Anxiety disorder		Paranoid personality disorder
	Bipolar disorder		Schizoaffective psychotic disorder
	Borderline personality disorder		Schizophrenic psychotic disorder
	Eating disorder		Other: (**specify:**_____
	Major depression		

2. Have you ever received mental health counseling or therapy from a mental health provider such as a psychologist, a psychiatrist, social worker or counselor?

☐ Yes

☐ No → **Skip to Q3**

☐ Refused

2a. Are you currently receiving mental health counseling or therapy from a mental health provider such as a psychologist, a psychiatrist, social worker or counselor?

☐ No

☐ Yes

☐ Refused

3. Have you ever been hospitalized for a mental or emotional illness?

☐ No

☐ Yes - IF YES, when (most recent if >1) MM/YYYY): ___ ___/___ ___ ___ ___

2013 MEDICAL CARE COORDINATION (MCC) ASSESSMENT

(READ ALOUD): Over the last 2 weeks, please tell me how much have you been bothered by any of the following by saying not at all, some days, more than half the days or nearly every day:

Depression Screening	Not at all	Some days	More than half the days	Nearly everyday
4. Little interest or pleasure in doing things	0	1	2	3
5. Feeling down, depressed, or hopeless	0	1	2	3
6. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
7. Feeling tired or having little energy	0	1	2	3
8. Poor appetite or overeating	0	1	2	3
9. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
10. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
11. Moving or speaking so slowly that other people would have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
12. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Anxiety Screening	Not at all	Some days	More than half the days	Nearly everyday
13. Feeling nervous anxiety or on edge	0	1	2	3
14. Not being able to stop or control worrying	0	1	2	3
15. Worrying too much about different things	0	1	2	3
16. Trouble relaxing	0	1	2	3
17. Being so restless that it is hard to sit still	0	1	2	3
18. Becoming easily annoyed or irritable	0	1	2	3
19. Feeling afraid as if something awful might happen	0	1	2	3

IF PATIENT HAD ANY OF THE PROBLEMS ABOVE (some days, more than half the days, or nearly everyday), then ASK:

20. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Would you say not difficult at all, somewhat difficult, very difficult or extremely difficult?

☐ Not difficult at all ☐ Somewhat difficult

☐ Very difficult ☐ Extremely difficult

21. Are you currently considering hurting yourself or others?

☐ No

☐ Refused

☐ Yes

- **If patient answers "yes" to Q21, or indicates they are in danger of hurting themselves or others**, seek consultation with the clinic supervisor immediately and/or refer to agency protocol.

- **If YES, but with no current plan**, ask to describe these feelings and how they stop themselves from acting on them:

_____

_____

INSTRUCTIONS: IF PATIENT HAS MENTAL HEALTH NEED AND IS NOT CURRENTLY RECEIVING MENTAL HEALTH CARE, ASK THE FOLLOWING QUESTION:

22. Are you interested in talking to someone about any mental health issues?

- ☐ NO (Patient is not ready or willing to seek mental health services -pre-contemplation)
- ☐ YES (Patient is thinking about seeking mental health services-contemplation)
- ☐ YES (Patient is interested in getting mental health services -ready for action)

Summary Notes:

Signatures

MCM _____ Date _____/_____/_____

PCM_____ Date _____/_____/_____