



INSURANCE SERVICES PROGRAM PHYSICIANS STATEMENT OF DIAGNOSIS

Patient Name: _____ SS#: _____

STEP 1: Check one of the following:

	This patient tested positive for HIV on: _____.
	This patient has NOT tested positive for HIV.

STEP 2: Please circle one of the following CDC Staging Classifications using the chart below AND the symptom charts in STEP 4 as guides:

A1 A2 A3 B1 B2 B3 C1 C2 C3

		Clinical Categories		
CD4 + T-cell Categories	CD4 + Percentage	(A) Asymptomatic Acute (primary) HIV or PGL	(B) Symptomatic Not (A) or (C) Conditions	(C) AIDS-Indicator Conditions
(1) > 500/uL	>29%	A1	B1	C1
(2) 200-499/uL	14-28%	A2	B2	C2
(3) <200/uL	<14%	A3*	B3	C3
AIDS Indicator T-cell count				

*A3 is an AIDS indicator, regardless of the presence of symptoms; therefore, the client is eligible for the Insurance Services Program

STEP 3: Most Recent Laboratory Values

CD4 (Absolute/Percent) _____/_____ % as of _____ (Date)
 Viral Load _____ copies per ML as of _____ (Date)

STEP 4: Please check the following Symptoms/Conditions the patient has had at any time since testing HIV positive.

A. Conditions Include:		
	PGL Persistent Generalized Lymphadenopathy	
	Acute (primary) HIV infection with accompanying illness or history of acute HIV infection	
	Asymptomatic HIV infection	
B. Category B consists of symptomatic conditions in an HIV infected adolescent or adult that are not included among conditions listed in clinical Category C and that meet at least one of the following criteria: (a) the conditions are attributed to HIV infection or are indicative of a defect in cell mediated immunity; or (b) the conditions are considered by physicians to have a clinical course or to require management that is complicated by HIV infection. Examples of conditions in clinical Category B include, but are not limited to:		
	Bacillary angiomatosis	Herpes zoster (shingles), involving at least two distinct episodes or more than one dermatoma
	Candidiasis, oropharyngeal (thrush)	Idiopathic thrombocytopenic purpura
	Candidiasis, vulvovaginal, frequent, or poorly responsive to therapy	Listeriosis
	Cervical dysplasia (moderate or severe)/cervical carcinoma in situ	Pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess

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The Health Councils, Inc. Attention: Barbara Hay
9455 Koger Boulevard, Suite 104 St. Petersburg, Florida 33702 FAX (727)570-3033

<input type="checkbox"/>	Constitutional symptoms, such as fever (38.5C) or diarrhea lasting > 1 month	<input type="checkbox"/>	Peripheral neuropathy
<input type="checkbox"/>	Hairy leukoplakia, oral	<input type="checkbox"/>	Other (please list):

C. Conditions Include:			
<input type="checkbox"/>	Candidiasis of bronchi, trachea, or lungs	<input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent term)
<input type="checkbox"/>	Candidiasis, esophageal	<input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent term)
<input type="checkbox"/>	Cervical cancer, invasive	<input type="checkbox"/>	Lymphoma, primary of brain
<input type="checkbox"/>	Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/>	Mycobacterium avium complex or M. Kansasii, disseminated or extrapulmonary
<input type="checkbox"/>	Cryptosporidiosis, chronic intestinal (>1 month duration)	<input type="checkbox"/>	Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
<input type="checkbox"/>	Cytomegalovirus disease (other than liver, spleen, or nodes)	<input type="checkbox"/>	Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
<input type="checkbox"/>	Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/>	Pneumocystis carinii pneumonia
<input type="checkbox"/>	Encephalopathy, HIV related	<input type="checkbox"/>	Pneumonia, recurrent
<input type="checkbox"/>	Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis	<input type="checkbox"/>	Progressive multifocal leukoencephalopathy
<input type="checkbox"/>	Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/>	Salmonella septicemia, recurrent
<input type="checkbox"/>	Isosporiasis, chronic intestinal (> 1 month duration)	<input type="checkbox"/>	Toxoplasmosis of brain
<input type="checkbox"/>	Kaposi's sarcoma	<input type="checkbox"/>	Wasting Syndrome due to HIV
<input type="checkbox"/>		<input type="checkbox"/>	Other (please list):

Patient's Release: *I hereby authorize you to release this completed Physician's Statement of Diagnosis to The Health Councils, Inc., which will use it to determine my eligibility for program services through the Insurance Services Program.*

Client Signature: _____

Physician Signature: _____

Physician Name: _____

Physician License Number: _____

Address: _____

City/State/Zip: _____

Phone: _____

Case Manager Name: _____

(Please print clearly)

Case Manager Phone: _____

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