Referral to Queensland Positive People

Please email form to referrals@qpp.org.au. For further enquiries, please call 1800 636 241.	Referral Date: / /

Details of the REFERRER

Name:		Position:	
Organisation:		Contact Phone:	
Email address:			
Has the client consented to this referral? ☐ Yes ☐ No			

New Client Details

Surname:		First Name:	
Home Phone:		Mobile Phone:	
Home address:			
Email:			
Can a message be left/contact made:	☐ By email ☐ On clients home phone ☐ On clients mobile phone ☐ By text to clients mobile phone		
Are there confidentiality concerns? ☐ No ☐ Yes-Details:			
Date of Birth: / /		Country of Birth:	
Medicare Eligibility: ☐ Eligible ☐ Ineligible		Interpreter required: ☐ No ☐ Yes-Language:	
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other			
Client identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither			
Does the client have a personal carer? ☐ No ☐ Yes-Details:			

Any issues for support identified by the referrer (or other relevant information):

☐ Peer Navigation (for newly diagnosed / HIV health literacy)	☐ Peer Group social activities	☐ Transport	☐ Alcohol & other drugs
☐ Treatment Support (access & adherence)	☐ Finances	☐ Mental Health	☐ Housing
☐ Stigma/Discrimination	☐ Legal/Immigration/Visa	☐ Employment	☐ Dental/Oral Health
Other relevant information:			
Issues identified by the client being referred:			

Risk Assessment

Previous physical assault ☐No ☐Yes Previous verbal aggression ☐No ☐Yes History of dangerous weapons use ☐No ☐Yes History of sexual harassment ☐No ☐Yes	If yes, Please specify:

Confirmation of HIV Status *(HIV status can only be confirmed by a client's GP, HIV Specialist, Sexual Health Nurse or POCT)*

I, (your name) confirm that the above named client is HIV positive.

Signature: Date: / /

Date of HIV diagnosis	Viral Load at last test *(optional)*	CD4 Count at last test *(optional)*	Date of last test
/ /			/ /

For POCT only: Has diagnosis been confirmed? ☐ Yes-Date: / / ☐ No ☐ Pending