

# HARBORVIEW MADISON CLINIC PRE-HAART ROUTING FLOWSHEET

PATIENT PHONE NUMBER(S)	RECENT CD4 / %	DATE	RECENT VL	DATE
<b>PRIMARY CARE PROVIDER</b> PREVIOUS ANTIRETROVIRALS:				
PROPOSED REGIMEN			Discussed treatment study participation? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Check any of the following possible barriers to adherence that apply to your patient:				
<input type="checkbox"/> Active substance abuse	<input type="checkbox"/> Untreated mental illness	<input type="checkbox"/> Acute situational stressors		
<input type="checkbox"/> Non-belief in antiretrovirals / disease	<input type="checkbox"/> History of non-adherence	<input type="checkbox"/> Fear of side effects		
<input type="checkbox"/> Other:				
PROVIDER NAME (PRINT NAME CLEARLY) & SIGNATURE		UPIN	DATE & TIME	

**PROVIDER: please give this form to front desk so that appointments can be scheduled**

<b>PHARMACY</b> NAME	APPOINTMENT DATE / TIME:				
EDUCATION CONDUCTED (SEE ORCA): <input type="checkbox"/> SUGGEST HAART <input type="checkbox"/> SUGGEST DELAY					
NAME & SIGNATURE	DATE & TIME				
<b>SOCIAL WORK / CASE MANAGER</b> <input type="checkbox"/> OOC <input type="checkbox"/> LAA <input type="checkbox"/> NWFC <input type="checkbox"/> MAD SW	APPOINTMENT DATE / TIME:				
ASSESSMENT <input type="checkbox"/> SUGGEST HAART NAME:					
CONDUCTED: (SEE ORCA) <input type="checkbox"/> SUGGEST DELAY					
NAME & SIGNATURE	DATE & TIME				
<b>NUTRITION</b> NAME:	APPOINTMENT DATE / TIME:				
ASSESSMENT CONDUCTED (SEE ORCA) : <input type="checkbox"/> SUGGEST HAART <input type="checkbox"/> SUGGEST DELAY					
NAME & SIGNATURE	DATE & TIME				
<b>HEALTH EDUCATOR</b> NAME	APPOINTMENT DATE / TIME:				
ASSESSMENT CONDUCTED (SEE ORCA) : <input type="checkbox"/> SUGGEST HAART <input type="checkbox"/> SUGGEST DELAY					
NAME & SIGNATURE	DATE & TIME				
<b>FOLLOWUP TRACKING OF APPOINTMENTS SCHEDULED</b> Outcome: <b>NS</b> = No-Show, <b>R</b> = Rescheduled, <b>C</b> = Cancel					
Type	DATE / OUTCOME	DATE / OUTCOME	DATE / OUTCOME	DATE / OUTCOME	DATE / OUTCOME
<b>PHARMACY</b>					
<b>NUTRITION</b>					
<b>SOCIAL WORK</b>					

<b>PROVIDER FOLLOW-UP APPT</b>	DATE	LIST FINAL PRESCRIPTIONS & DATE DISPENSED (PHARMACY ONLY)
EDUCATION ON MEDICATIONS RECEIVED AT TIME OF DISPENSING?		<input type="checkbox"/> BROKEN HAART REASON _____
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PATIENT REFUSED		

*PreHaart Routing Flowsheet H1515 Mar 2005*

PT.NO

NAME

DOB

**UW Medicine**  
Harborview Medical Center – UW Medical Center  
University of Washington Physicians  
Seattle, Washington

**PRE-HAART ROUTING FLOWSHEET**



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