BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

HIV Drug Treatment Program
ENROLMENT FORM

Providence Health Care

OFFICE USE ONLY
BC-CfE #

Completion of this form is required only ONCE for each patient at the time of **initial enrolment** in the HIV Drug Treatment Program.

Return completed form to the BC Centre for Excellence in HIV/AIDS:
By Fax: 604-806-9044 **By Mail:** 687-1081 Burrard Street, Vancouver BC V6Z 1Y6 Telephone: 604-806-8515

Please also complete the HIV PRESCRIPTION REQUEST form to request specific drug therapy, as required.

Enrolling Prescriber Information

First Name, Last Name	MSC #: CPSID#:	Telephone:
Address, City	Postal Code:	Fax:

If another prescriber will be authorizing prescription refills, please indicate in the Follow-up Prescriber section of Prescription Form

Patient Information

First Name(s): | Last Name:

Sex at Birth: ☐ Male ☐ Female

Gender Identity: ☐ Man ☐ Woman ☐ Other: _____

Date of Birth: DD____ MON_____ YYYY_____

BC Personal Health Number (PHN): | Other Health Plan Billing Number: | Other Health Plan Name:

First HIV Positive Date: DD_____ MON_____YYYY_____ (HIV serology date, or antigen date if age is 15 months or less)

Antiretroviral Therapy (ART) Usage History (Check all that apply)**:**

a) Has the patient previously taken ART for **PREVENTION of HIV infection?**

☐ Pre-exposure Prophylaxis (PrEP) ☐ Post-exposure Prophylaxis (PEP, nPEP) ☐ Unknown

b) Has the patient previously taken ART for **TREATMENT of HIV infection?**

☐ Never Treated (ARV naive) ☐ Previously treated (but currently off ART) ☐ Currently taking ART ☐ Unknown

AIDS Defining illness:

Has the patient ever experienced an AIDS defining illness, as defined by BC-CDC? (see www.bccdc.ca)

☐ Yes ☐ No ☐ Unknown

If yes, specify event(s) and date(s): _____ MON_____ YYYY_____

_____ MON_____ YYYY_____

_____ MON_____ YYYY_____

Race/Ethnicity:

Does this individual self-identify as an Indigenous person? ☐ Yes ☐ No ☐ Unknown ☐ Prefer not to answer

If Yes, ☐ First Nations ☐ Métis ☐ Inuit ☐ Other: _____

If the individual does not self-identify as an Indigenous person, how does this individual self-identify? (Check all that apply)

☐ Black ☐ East Asian ☐ Latin American ☐ Middle Eastern ☐ South Asian ☐ Southeast Asian

☐ White ☐ Other: _____ ☐ Unknown ☐ Prefer not to answer

HIV Transmission Risk Factors (check all that apply)

☐ Sexual Exposure, Heterosexual ☐ Sexual Exposure, Same Sex Partner ☐ Sex Work

☐ Injection Drug Use ☐ Blood/Blood Product Recipient ☐ Perinatal (Mother to Child Transmission)

☐ Other Risk: _____ ☐ Unknown Risk

Enrolling Prescriber's Signature

Prescriber's Signature: _____ **Date:** DD_____ MON_____ YYYY_____