



AIDS Connecticut

110 Bartholomew Ave, Ste 3050, Hartford CT 06106 • T 860-247-AIDS • F 860-951-4779 • aids-ct.org

Early Intervention Services Program: Reconnect to Care Referral Form

**Please include a current Release of Information (to EIS), Consent Agreement, Medical Evaluation, Client ID, Service Plan and copy of photo ID.

Date: _____

Referring Agency/Address: _____

Contact Person: _____

Phone: _____ Fax: _____ Email: _____

| | |
|---|---|
| Client ID: | |
| Client Name: | |
| Client Address: | |
| Client City & Zip Code: | |
| Client Home Phone: | |
| Client Cell Phone: | |
| Alternate Contact Name: | |
| Alt. Contact Relationship: | |
| Alt. Contact Address: | |
| Alt. Contact Home Phone: | |
| Alt. Contact Cell Phone: | |
| Alternate Locations (e.g., soup kitchens) | |
| Race: | White Black Hispanic Asian Other: _____ |
| Disease Status: | HIV AIDS Diagnosis Date: _____ |
| Substance Abuse History: | No Yes Comments: _____ |
| Mental Health History: | No Yes Comments: _____ |
| Support Systems: | Please indicate where client may go to for support. |
| How long has client been out of care? | |
| Last kept medical appt: | |
| Next medical appt: | |
| Last kept MCM appt: | |
| Next MCM appt: | |
| Other (e.g., identifying features, personality characteristics) | |
| Additional Notes: | |