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:	