State of California – Health and Human Services Agency California Department of Public Health

Diagnosis Form

This form must be completed and signed by a licensed physician or other licensed healthcare provider. Physicians or healthcare providers are to complete this form in its entirety to indicate that the patient below is living with HIV or AIDS.

Client/ Patient Information

Name (First, M.I., Last):_____

Date of Birth:_____

Diagnosis Verification: Please select the box that applies and complete the section

Confirmatory HIV Positive Result: Complete below if the client has a confirmatory HIV Positive Result.

I_____ (enter licensed physician or other licensed healthcare provider name) hereby certify the client/patient is living with HIV or AIDS. I hereby certify that the information provided is factual, accurate, and complete.

Pending HIV lab: Complete below if the client has a rapid test.

I_____ (enter licensed physician or other licensed healthcare provider name) hereby certify the client/patient completed one positive rapid assay pending confirmatory HIV lab test (client will need to be placed on a 30-day Temporary Access Period by the ADAP Enrollment Worker and must provide confirmatory HIV lab within 30 days).

Diagnosis

☐ HIV – Not AIDS ☐ AIDS – As defined by the CDC

Licensed Health Care Provider Information

Licensed Healthcare Provider Name:_____

Licensed Healthcare Provider National Provider Identifier (NPI): _____

Medical License Number *(registered nurses only)*: _____

Hospital/ Clinic Name:_____

Hospital/ Clinic Address:_____

Phone:_____Date:_____

Licensed Physician or Healthcare Provider Signature:_____