

Thomas O. Forslund, Director

Governor Matthew H. Mead

**HIV SERVICES PROGRAM
PROVIDER'S MEDICAL CERTIFICATION FORM**

**APPLICANT: DO NOT COMPLETE - TO BE COMPLETED BY HEALTH CARE
PROVIDER ONLY**

The information on this form is necessary to determine your patient's eligibility for services offered by the HIV Services Program. All information on this form or given over the telephone will be kept strictly confidential by the Wyoming Department of Health. Personal identifying information is never released.

PATIENT LAST NAME:	FIRST NAME:	MIDDLE NAME:
PATIENT ADDRESS:		
PATIENT DATE OF BIRTH:		

Diagnosis of HIV infection? YES NO

Year of initial diagnosis, if known: _____

State of initial diagnosis, if known: _____

Plasma RNA Viral Load: _____ copies/ml Date: _____

Current CD4 Count: _____ Date: _____

Is this patient naive to antiretroviral therapy? YES NO

PROVIDER SIGNATURE: _____

PRINTED NAME: _____

ADDRESS: _____

TELEPHONE: _____ DATE: _____

**PLEASE RETURN THIS FORM TO THE ADDRESS SHOWN BELOW.
THANK YOU FOR YOUR COOPERATION.**