PHYSICIAN DIRECTION FORM

Based on my review of the client’s Health Questionnaire, medical, and drug history the following client:

Client Name__________________________________    Client ID#_______________________________

1. □ Must have the following tests and/or examinations to screen for infectious or communicable disease:________________________________________________________________________
   After my orders are completed, the results must be returned to me for review. The client may not participate in the program while the tests are being completed.

2. □ Should have the following tests and/or examinations to rule out infectious or communicable disease and provide further information for treatment planning purposes:________________________
   The results may be returned to me for review and further input into treatment planning.

3. □ May be referred for the following tests and/or examinations for his/her own information and health promotion:________________________________________________________________________

____________________________________________ ______________________________
Medical Director’s Signature    Date

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MEDICAL DIRECTOR FOLLOW-UP

Based on my follow-up review of the results of the above tests and/or examinations, the client:

1. □ May participate in the program.

____________________________________________ ______________________________
Medical Director’s Signature    Date

HIV testing, other than court ordered testing, cannot be mandated.