CBO ORIGINAL PATIENT INFORMATION FORM <HIGHLY CONFIDENTIAL>

ORIGINAL PATIENT (O.P.) INFORMATION

Date Counseled	Organization	D Number / Sticker			
Last Name	First Name , M.I.	Nickname	Gender ☐ M ☐ F ☐ T	Age	D.O.B.
Race: ☐ W ☐ B ☐ AP ☐N Am ☐ Other	Ethnicity: ☐ Hispanic ☐ Non-His.	Marital Status: ☐ S ☐ M ☐ D /Sep ☐ Unknown			
Pregnancy Status ☐ Pregnant ☐ Not Pregnant ☐ Unknown	Health Care Provider (if known)				
Lives with, and/or Special Considerations (if any):	Street Address	City/State			
Phone #'s with Area Codes, in order of best to reach O.P.:	☐ Home ☐ Cell ☐ Work ☐ Other (specify)	( )			
	☐ Home ☐ Cell ☐ Work ☐ Other (specify)	( )			
	☐ Home ☐ Cell ☐ Work ☐ Other (specify)	( )			
E-mail Address	Is O.P. aware that the DIS will contact him/her? ☐ Y ☐ N				
Has patient had HPS in the past? ☐ Y ☐ N If yes, when:	Preferred way for DIS to contact O.P.				

PARTNER INFORMATION

☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.
☐ Sex Partner ☐ Needle Sharing ☐ Both Type of Referral: ☐ DIS ☐ Client ☐ Dual ☐ Contract	Partner Last Name	First Name , M.I.

Attach additional forms if needed.