

# ARIES DATA FORMS

Entered Into ARIES

RWP Required Fields (if applicable) = Orange Boxes

Staff Member Completing Form: \_\_\_\_\_

Client Name: \_\_\_\_\_

Chart Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

## Client Search:

1. The initial search determines if the client is already registered in ARIES with your agency.
2. If the client is not found, the system will ask you to broaden your search. For example, if you searched “Prince” (first name) and “Charming” (last name) on the first attempt, try leaving the first name blank and enter only “Char\*” (C-h-a-r with an *asterisk*) or some other, shorter version of the last name you are searching. This will help to ensure duplicates are not created in the system due to spelling errors and the like.
3. If the client is still not found, click “Create New Client”.

**IMPORTANT:** If the client informs you that they are already in ARIES but you are unable to pull up their record, please call either the ARIES Helpdesk or the Ryan White Program for assistance to avoid the creation of a duplicate record.

- No records found. Try broadening your search.

## Client Search

To find a client, or to check if a client is new to your agency, enter in some or all of the following information. You may use the wildcard \*.

Last Name	<input type="text"/>	
First Name	<input type="text"/>	
Middle Initial	<input type="text"/>	
Client ID	<input type="text"/>	
SSN	<input type="text"/>	123-45-6789
Date of Birth	<input type="text"/>	mm/dd/yyyy
Display	<input type="text" value="20"/> results	

Search Related/Affected Individuals

*Recommendation:*  
Use last name only (e.g. Charming) or partial last name with an asterisk (e.g. Char\*) for initial search.

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

## Adding Client:

1. If the client was not found in your agency in the search process mentioned above, the system will ask you to enter the 6 identifiers to search the entire ARIES system for the individual. *Note: The identifiers must be entered exactly to find a client that has already been entered into ARIES by another agency and to avoid creating a duplicate entry.*
2. If the client is not found, the system will ask you to check your entries and search once more.
3. If the client is still not found, you will need to create a new client record by tabbing through each field and clicking "Create".
4. **\*\*\*Be certain to obtain a signed ARIES Consent form from the client before proceeding.**

## Client URN

To check if this client may already be registered in ARIES, please accurately enter the following data:

No match was found. Please check your entries and search again. To create a new client record, verify the value in each field by tabbing through it and then click on the Create button.


Last Name \*

First Name \*

Disable ARIES capitalization - save name as entered

Middle Initial \*

Mother's Maiden Name \*

Date of Birth \*  

Gender \*

Client agrees to share data

*Tip: If client does not have middle initial or there is no way for you to obtain their middle initial, leave this field **blank**.*


*Tip: If client does not want to give their full Mother's Maiden Name, enter only the first 3 letters of their mother's maiden name. If the client will not give the first 3 letters OR the client does not know their mother's maiden name, use the client's last name. Example: Prince Charming = Charming. If the name is less than 3 characters, simply enter the letters available. **Instruct the client to use the same convention when enrolling at other agencies.***

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

Demographics: Contact Info: Contact Information: Addresses

 **ADDRESSES**

	Residence	Mailing	Previous	Emergency Contact
Since	<input type="text"/>	<input type="checkbox"/> Same as Residence	<input type="text"/> <input type="checkbox"/> Same as Residence	<div style="border: 1px dashed red; padding: 5px;"><p>Name <input type="text"/></p><p><input type="text"/></p><p><input type="text"/></p><p><input type="text"/></p><p>State &amp; Zip <input type="text"/> <input type="text"/></p><p>Tel1 <input type="text"/></p><p>Tel2 <input type="text"/></p><p><b>Confid</b> <input type="text"/> Yes/No <b>Msgs OK</b> <input type="text"/> Yes/No</p></div>
Street 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Street 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
City	<input type="text"/>	<input type="text"/>	<input type="text"/>	
State & Zip	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
County	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Geog Area/HSDA	<input type="text"/>	<input type="text"/>	<input type="text"/>	
May we contact you by mail?	<input type="text"/> Yes/No			
Should mail be confidential?	<input type="text"/> Yes/No			
Note:			<input type="text"/>	

Or if not the same as Residence, input **Street1**, **City**, **Zip**, and **County** for Mailing.

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

Demographics: Contact Info: Contact Information: Phone



## PHONE AND EMAIL

	Phone Type	Allow Contact	Confid	Msgs OK
Phone 1	<input type="text"/>	<input type="text"/> Yes/No	<input type="text"/> Yes/No	<input type="text"/> Yes/No
Phone 2	<input type="text"/>	<input type="text"/> Yes/No	<input type="text"/> Yes/No	<input type="text"/> Yes/No
Email 1	<input type="text"/>	(home, mobile, etc.) <input type="text"/> Yes/No	<input type="text"/> Yes/No	<input type="text"/> Yes/No

## Demographics: Demographic Detail: Identifiers

Last Name \*  \*

First Name \*

Disable ARIES capitalization, save name as entered

Middle Initial \*

Mother's Maiden Name \*

Date of Birth \*

Gender \*  \*

*Tip:* If client does not have middle initial or there is no way for you to obtain their middle initial, leave this field **blank**.

*Tip:* If client does not want to give their full Mother's Maiden Name, enter only the first 3 letters of their mother's maiden name. If the client will not give the first 3 letters OR the client does not know their mother's maiden name, use the client's last name. Example: Prince Charming = Charming. If the name is less than 3 characters, simply enter the letters available. **Instruct the client to use the same convention when enrolling at other agencies.**

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## Demographics: Demographic Detail: Demographics

Client Name: \_\_\_\_\_

AKA

Hispanic \*  \* Yes / No

Race

1 \*  \*

2

3

SSN

Marital Status

Sexual Orientation

Primary Language

Secondary Language

Place of Death  (e.g. home, hospital, nursing facility, etc)

Other:

Date of Death \*

Nat'l Orig/Ethnic.

Education Level

Veteran

Special Needs

Notes

If a client is undocumented, use 999-99-9999.

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

## Demographics: Living Situation: Living Situation

Current Living Situation \*

Living Situation since \*

If rent or own, do you have a signed lease, title or tax receipt?

Housing Assistance   
HOPWA, HUD, Section 8, etc.

HUD Application Date

### Living Situation in last 12 months (check all that apply):

- Homeless from the streets
- Living with relatives/friends
- Homeless from emergency shelter
- Rental Housing
- Transitional housing
- Participant-owned housing
- Psychiatric facility
- Board care or assisted living
- Substance abuse treatment facility
- Rented room
- Hospital or other medical facility
- Refused to answer
- Jail/Prison
- Other
  
- Unknown

# ARIES DATA FORMS

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## Demographics: Living Situation: Related or Affected Individuals

Client Name: \_\_\_\_\_

Last Name *	<input type="text"/>		
First Name *	<input type="text"/>	<input type="checkbox"/> Living with client	
	<input type="checkbox"/> Disable ARIES capitalization, save name as entered	Street	<input type="text"/>
Middle Initial	<input type="text"/>	City	<input type="text"/>
Date of Birth *	<input type="text"/>	State	<input type="text"/>
Mother's Maiden Name *	<input type="text"/>	ZIP Code	<input type="text"/>
Gender *	<input type="text"/>	County *	<input type="text"/>
Relationship *	<input type="text"/> (Other) <input type="text"/>	Phone 1	<input type="text"/>
Enrollment Date *	<input type="text"/>	Living Situation *	<input type="text"/>
Enrollment Status *	<input type="text"/>	Annual Household Income *	<input type="text"/>
Status As Of *	<input type="text"/>	# People in HH	<input type="text"/>
Date of Death	<input type="text"/>	Federal Poverty Level	<input type="text"/>
Hispanic *	<input type="text"/>	Medical Insurance *	<input type="text"/>
Race 1 *	<input type="text"/>		
Race 2	<input type="text"/>		

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## Demographics: Agency Specifics: Agency Specifics

Client Name: \_\_\_\_\_

**Agrees to Share Data**  Yes  No

**Agency Status \***  \*

**Status as of Date \***  \*

**Agency Enrollment Date \***  \*

**Agency Client ID 1**

**Agency Client ID 2**

**Agency User Field 1**

**Agency User Field 2**

**Client Alert**

**Reason for Status Change**

**if Other**

**Referral Date**

**Referral Source**

**if Other**

## Eligibility: Eligibility Documents: Eligibility Documents

Type	Pending	Doc Dated	Obtained	Expires	Source	Location	Note
Agency Consent Form →	<input type="text"/>						<i>Must be your agency location.</i>
ARIES Consent Form →	<input type="text"/>						<i>Must be your agency location.</i>
HIPAA →	<input type="text"/>						<i>Must be your agency location.</i>
Proof of Diagnosis →	<input type="text"/>				<input type="text"/>		
Proof of Income →	<input type="text"/>		<input type="text"/>		<input type="text"/>		
Proof of Residency →	<input type="text"/>		<input type="text"/>		<input type="text"/>		



# ARIES DATA FORMS

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**Eligibility: Financial: Financial: Client Income**

Client Name: \_\_\_\_\_



## CLIENT INCOME

(Amounts are monthly)

Employed

Full Time, Part Time, Not Employed, etc.

Public Assistance

Employment/Wages

State Disability Ins/SDI

Retirement

Supp Security Income/SSI

Long-term Disability/LTD

Investment

Soc Sec Disability Ins/SSDI

Worker's Compensation

Gift

Social Security Retirement

TANF CalWORKS

other 1

Gen Assist/Gen Relief GA/GR

Veterans Benefits/VA

other 2

Unemployment/UI

Alimony/Child Support

other 3

Total

**calculates**

No source of income

Food Stamps

# ARIES DATA FORMS

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**Eligibility: Financial: Financial: Household Income**

Client Name: \_\_\_\_\_



## HOUSEHOLD INCOME

Monthly Household Income \*

# People in Household \*

# Children in Household

Percent Federal Poverty Level

# HIV+ People in Household



## FAMILY INCOME

Monthly Family Income

# People in Family

Percent Federal Poverty Level



## ASSETS

Do you own: a house?  a car?

Do you have other assets?

Dollar Amount of Other Assets



## INCOME HISTORY

Date	Monthly Client Income	Monthly Household Income	Monthly Family Income
------	-----------------------	--------------------------	-----------------------

Edit

New

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Client Name: \_\_\_\_\_

**Eligibility: Insurance: Insurance**

Source *	Type	Pending	Prim Ins *	Prim HIV Ins	Carrier	Policy #	Start Date *	End Date *	Mo. Premium	Note
----------	------	---------	------------	--------------	---------	----------	--------------	------------	-------------	------

- ADAP
- Public 1
- Public 2
- Private 1
- Private 2
- Private 3
- Vision
- Dental
- Medi-Cal/Medicaid
- Veteran
- Medicare
- Other public insurance
- Other
- Unknown
- No insurance

- Baby
- CA Children's Services
- Cal-COBRA
- CHAMPUS
- CHIPPS
- CMSP
- COBRA
- COBRA-FAMILY
- COBRA-INDIVIDUAL
- Conversion (Rx)
- CONVERSION-FAMILY
- CONVERSION-INDIVIDUAL
- County Sponsored
- DentiCAL
- FAMILY MEDICAL LEAVE ACT
- FAMILY-SELF PAY
- Full Scope
- HIPIC
- INDIVIDUAL-SELF PAY
- LIHP
- Managed
- Medicare A
- Medicare A & B
- Medicare D
- No Insurance
- North Star
- OBRA
- OBRA-FAMILY
- OBRA-INDIVIDUAL
- Other
- Private Self-pay
- Restricted
- Shared Cost
- Unknown
- Veterans

- Blue Cross
- Kaiser
- Aetna
- Other

Only enter an END DATE if the insurance has a definite END DATE or has already expired.





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Client Name: \_\_\_\_\_

**Programs Tab → Not Ryan White Programs, therefore, not Ryan White requirement.**

**Medical: Basic Medical: Basic Medical**

	Name	Phone	Last Visit
Primary Med Care	<input type="text"/>	<input type="text"/>	<input type="text"/> 
	Same choices as below		
Primary HIV Care	<input type="text"/>	<input type="text"/>	<input type="text"/> 
	<ul style="list-style-type: none"><li>Alternative/complementary ca</li><li>County hospital and DPH Clir</li><li>Community-based clinics, pu</li><li>Community-based clinics, pri</li><li>HMO hospital/clinics (e.g., K</li><li>VA hospital, CHAMPUS</li><li>Federally qualified health cen</li><li>Other</li><li>Private MD</li><li>Emergency room</li><li>No primary care</li></ul>		
CDC Disease Stage *	<input type="text"/>	* Source	<input type="text"/>
	<ul style="list-style-type: none"><li>HIV Negative</li><li>HIV positive, disease stage unknown</li><li>HIV positive, asymptomatic</li><li>HIV positive, symptomatic, not AIDS</li><li>HIV positive, disabling</li><li>CDC-Defined AIDS</li><li>Disabling AIDS</li><li>Pediatric indeterminate</li><li>Pediatric, confirmed HIV positive</li><li>Unreported</li><li>Unknown</li></ul>		
	<ul style="list-style-type: none"><li>Letter of Diagnosis</li><li>Medical Record</li><li>Awaiting Letter of Diagnosis</li><li>Not Applicable</li><li>Lab Results</li></ul>		
Date First HIV+	<input type="text"/> 	Year First HIV+	<input type="text"/>
AIDS Diag Date *	<input type="text"/> 	County	<input type="text"/>
		State	<input type="text"/>
		Source	<input type="text"/>

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

Medical: Basic Medical: Basic Medical: HIV Tests



## HIV TESTS

HIV Test Date *	Result	County	State	Source	Pre-test Counseling *	Post-test Counseling *
<input type="text"/> *	<input type="text"/> * Positive Negative Indeterminate	<input type="text"/>	<input type="text"/>	<input type="text"/>	Offered / Not Offered <input type="text"/> * <input type="text"/>	Offered / Not Offered <input type="text"/> * <input type="text"/>


Save  
Cancel  
Deactivate

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

Medical: Basic Medical: Basic Medical: AIDS Defining Conditions



 <b>AIDS DEFINING CONDITIONS</b>		
AIDS Defining Condition *	Diagnosis Date *	Treatment Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Bacterial infections, multiple or recurrent (under 13 only)	<input type="text"/>	<input type="text"/>
Candidiasis, bronchi, trachea, or lungs		
Candidiasis, esophageal		
Carcinoma, invasive cervical (Adult only)		
CD4 Count less than 200 or CD4 Percent less than 14		
Coccidioidomycosis, disseminated or extrapulmonary		
Cryptococcosis, extrapulmonary		
Cytomegalovirus disease (other than in liver, spleen, or nodes)		
Cytomegalovirus retinitis (with loss of vision)		
HIV encephalopathy		
Herpes simplex: ulcers >1 mo; bronchitis/pneumonitis/esophagitis		
Histoplasmosis, disseminated or extrapulmonary		
Isosporiasis, chronic intestinal (>1 month duration)		
Kaposi's sarcoma		
Lymph interstitial pneumonia, pulmonary hyperplasia (und13 only)		
Lymphoma, Burkitt's (or equivalent term)		
Lymphoma, immunoblastic (or equivalent term)		
Lymphoma, primary in brain		
MAC or M. kansasii, disseminated or extrapulmonary		
M. tuberculosis, pulmonary (Adult only)		
M. tuberculosis, disseminated or extrapulmonary		
Mycobacterium of other/unknown species, dissem. or extrapul.		
Pneumocystis carinii pneumonia		
Pneumonia, recurrent, in 12-month period (Adult only)		
Progressive multifocal leukoencephalopathy		
Salmonella septicemia, recurrent (Adult only)		
Toxoplasmosis of brain		
Wasting syndrome due to HIV		
Other Diagnosis		
Cryptosporidiosis, chronic intestinal (>1 month duration)		
	if Other: <input type="text"/>	

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

Medical: Basic Medical: Basic Medical: Acuity Scale / Weight

Acuity Scale	Acuity Score	Date
<input style="border: 2px solid orange;" type="text"/> 	<input style="border: 2px solid orange;" type="text"/>	<input style="border: 2px solid orange;" type="text"/> 
<ul style="list-style-type: none"><li>Beck Depression Invento</li><li>Brief Symptom Inventory</li><li>Karnofsky/CFA</li><li>Pediatric</li><li>Self-Management</li><li>Other</li><li>Unknown</li></ul>		

Weight	Date
<input type="text"/>	<input type="text"/> 

Usual Weight

Medical: Basic Medical: Basic Medical: Partner Notification

Partner Notification Offered   Yes / No

Dated  

# Partners to be Notified by Client

# Partners to be Notified by Health \*   
Department

Date Health Dept Notified \*  

Medically unable to work   Yes / No

Dated  

Other chronic medical conditions

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Medical: Medical History: Medical History: Tests / CD4 and Viral

CD4 Date *	T Cell Count *	%	Viral Load Date *	<=>	Value *	Test Type	Log
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<ul style="list-style-type: none"> <li>Roche PCR St</li> <li>Roche PCR UI</li> <li>Bayer bDNA</li> <li>BioMerieux Nu</li> </ul>	

**NOTE:** Both CD4 and Viral Load test results should be collected **twice annually** at a minimum....and at least **90 days apart** to measure progress.

## Medical: Medical History: Medical History: Tests / STI Hepatitis

STI/Hepatitis *	Date *	Diagnosis *	Lab Value	Tx Ind? *	Treatment Start Date *	Treatment End Date	Outcome	Notes
<ul style="list-style-type: none"> <li>Genital herp</li> <li>Gonorrhea</li> <li>Human papi</li> <li>Syphilis</li> <li>Non-specific</li> <li>Hepatitis A</li> <li>Hepatitis B</li> <li>Hepatitis C</li> <li>HSV-1</li> <li>HSV-2</li> <li>Chlamydia</li> </ul>	<input type="text"/>	<input type="checkbox"/> is not medically indicated <ul style="list-style-type: none"> <li>Negative diag</li> <li>Positive diag</li> <li>Presumptive</li> <li>Indeterminate</li> <li>Unknown</li> </ul>	<input type="text"/>	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> <li>Patient Refus</li> </ul>	<input type="text"/>	<input type="text"/>	<ul style="list-style-type: none"> <li>Completed</li> <li>Not Completed</li> <li>Unknown</li> <li>Not applicable</li> </ul>	<input type="text"/>



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Client Name: \_\_\_\_\_

## Medical: Medical History: Medical History: Tests / Tuberculosis

### Tuberculosis

TB Test Medically Indicated \*  Yes / No

TB Test Medically Indicated \*  Date

Date PPD/TST Placed \*

Date PPD/TST Read \*

IGRA Date \*

Chest X-Ray Date \*

TB Diagnosis \*   
 None  
 Active  
 Inactive  
 History of Positive PPD  
 Unknown

PPD/TST Result  Reactive / Non

IGRA Result  Pos / Neg

Chest X-Ray Result  Pos / Neg

Date of TB Diagnosis \*

Treatment Start Date \*

Multi-Drug Resistance \*  Yes / No

Treatment End Date \*

TB Treatment Type *	TB Treatment Status *	Date *
<input type="text"/> N/A Treatment Prophylaxis None Unknown	<input type="text"/> In progress Completed Not completed N/A Unknown	<input type="text"/>

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

Medical: Medical History: Medical History: Immunizations



## IMMUNIZATIONS

Immunization Type \* Is not medically indicated \* Date \*

<input type="text" value=""/>	<input type="checkbox"/> Is not medically indicated	<input type="text" value=""/>
-------------------------------	---	-------------------------------

BCG  
 Flu  
 Hepatitis A  
 Hepatitis B - Dose 1  
 Hepatitis B - Dose 2  
 Hepatitis B - Dose 3  
 PCP  
 Pneumovax  
 Tetanus  
 Other

Medical: Medical History: Medical History: ER / Hospital Visits



## ER / HOSPITAL VISITS

Date ER Visit Reason Hospitalized If hospitalized, # of days

<input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>	<input type="text" value=""/>
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HIV Related, no OI  
 AIDS Related, no OI  
 OI (HIV/AIDS)  
 Not HIV/AIDS Related  
 Other

# ARIES DATA FORMS

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Client Name: \_\_\_\_\_

## Medical: OB/GYN & Pregnancy: Ob/Gyn & Pregnancy: Pap Smear/Pelvic Exam – Pregnancy History

Primary Ob/Gyn  
Phone


Pap Smear & Pelvic  
Exam Dates \*

Result



Primary healthcare provider strictly an Ob/Gyn practitioner

### Pregnancy History

Date first reported pregnant \*

Estimated Date of Conception \*

Estimated Delivery Date [Date Calculator](#) \*

HIV Status During Pregnancy \*

HIV positive after conception  
HIV positive prior to pregnancy

Date Prenatal Care Began \*

Number of Prenatal Visits in Reporting Month

ART Counseling offered to reduce HIV transmission to infant \*

 Yes / No

Date Received ART Counseling \*

ART was offered to reduce vertical transmission to infant \*

 Yes / No

Date ART was taken \*

Pregnancy Outcome \*

Live birth  
Therapeutic (induced) abortion  
Spontaneous abortion (miscarriage)  
Stillbirth  
Unknown

Date of Pregnancy Outcome \*

Newborn HIV Status \*

  
 Positive  
 Negative  
 Indeterminate  
 Unknown

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Client Name: \_\_\_\_\_

## Medications: ART: ART Medications: ART Type / Anti-Retroviral Drugs / Adherence

	Name	Phone	Allergies
Pharmacy 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pharmacy 2	<input type="text"/>	<input type="text"/>	
Pharmacy 3	<input type="text"/>	<input type="text"/>	

### ART TYPE

ART Type *	Reason not on HAART *	Start Date *	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Highly Active Anti-Retroviral Therapy (HAART) (Triple Therapy) Combination Anti-Retrovirals but not HAART (Dual Therapy) Mono therapy Salvage therapy None/not applicable Unknown/Unreported	Not medically indicated Not ready (determined by clinician) Client refused Intolerance, side-effects, toxicity Payment assistance unavailable Other Unknown		

### ANTI-RETROVIRAL DRUGS

Anti-retroviral Drugs *	Prescribed by	Side Effects	Start Date	End Date	Dosage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Agenerase (amprenavir) (d04428) Aptivus (tipranavir) (d05538) Atripla (tenofovir DF/emtricitabine/efavirenz) (d04219) Combivir (lamivudine-zidovudine) (d04219) Crixivan (indinavir) (d03985) Emtriva (emtricitabine) (d04884) Epivir (lamivudine) (d03858) Epzicom (abacavir-lamivudine) (d05354) Fortovase (nirvase/saquinavir) (d03860) Fuzeon (enfuvirtide) (d04853) HIVID (ddC, zalcitabine) (d00127)	Intelence (etravirine) (d07076) Isentress (raltegravir) (d07048) Kaletra (lopinavir-ritonavir) (d04717) Lexiva (fosamprenavir) (d04901) Norvir (ritonavir) (d03984) Other (Other) (d99999) Prezista (darunavir, TMC-114) (d05825) Rescriptor (delavirdine) (d04119) Retrovir (AZT, ZDV, zidovudine) (d00034) Reyataz (atazanavir) (d04882) Selzentry (maraviroc) (d06852)	Sustiva (efavirenz) (d04355) Trizivir (abacavir/lamivudine/zidovudine) (d04355) Truvada (emtricitabine-tenofovir) (d05352) Videx (ddI, idanosine, deoxyinosine) (d04355) Viracept (nelfinavir) (d04118) Viramune (nevirapine) (d04029) Viread (tenofovir) (d04774) Zerit (stavudine) (d03773) Ziagen (abacavir) (d04376)			

### Adherence

In the last three days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor?  as of

Adherence to HIV Treatment: **Percent of doses taken in the past four weeks**  **Date**

Genotypic/Phenotypic testing performed to determine resistance to HIV medications?  Date of Test:

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Client Name: \_\_\_\_\_

## Medications: Other Medications: Other Medications: Other Medications

Other Medications *	Prescribed by	Used for *	Type *	Start/End Date *	Dosage
<input type="checkbox"/> Check if Other Drug			<input type="text" value="Prophylaxis Treatment"/>	<input type="text"/>	<input type="text"/>

### Adherence

In the last three days, not including today, how many days did you take your other medications at the times and in the amounts prescribed by your doctor?  as of

## Risk & Assessments: Risk Factors: Risk Factors

Pediatric

\* What behaviors did the client engage in prior to his/her first HIV positive test result? Check all that apply:

#### Client Risk Factors

- Sex with Male
- Sex with Female
- Injected nonprescription drugs
- Received clotting factor for hemophilia/coagulation disorder
- Received transfusion of blood/blood components (other than clotting factor), transplant of tissue/organs or artificial insemination
- Worked in healthcare or clinical lab setting
- Mother HIV infected/Perinatal transmission
- Sexual abuse (pediatric only)
- Other
- Unknown

#### Sex Partner Risk Factors, Heterosexual Contact ONLY

- Intravenous/injection drug user
- Bisexual Male
- Person with AIDS or documented HIV
- Other (person with hemophilia/coagulation disorder, transfusion recipient with documented HIV infection, Transplant recipient with documented HIV infection)
- Unknown

#### Primary HIV Exposure

#### Secondary HIV Exposure

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Substance Abuse: Substance Abuse

Does the client have a history of substance abuse?

Substance Abuse History

No  
 Yes, active problem within the last 3 months  
 Yes, but not active within the last 3 months  
 Unknown

Dated

Daily / Monthly / Weekly

Age First Used

Frequency

Treatment Status	Date
<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>In treatment</li> <li>Waiting list for treatment</li> <li>Refused treatment</li> <li>Completed treatment</li> <li>Pre-treatment process</li> <li>Dropped out of treatment</li> <li>No active treatment or counseling</li> <li>Resumed treatment</li> <li>Other</li> <li>Unknown</li> <li>Not applicable</li> </ul>	

Screen Date	Screening Tool	Outcome
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Risk & Assessments: Mental Health: Mental Health

Does the client have a history of mental illness?

Treatment Status	Date
<input type="text"/>	<input type="text"/>
<ul style="list-style-type: none"> <li>In treatment</li> <li>Waiting list for treatment</li> <li>Refused treatment</li> <li>Completed treatment</li> <li>Pre-treatment process</li> <li>Dropped out of treatment</li> <li>No active treatment or counseling</li> <li>Resumed treatment</li> <li>Other</li> <li>Unknown</li> <li>Not applicable</li> </ul>	

Screen Date	Screening Tool	Outcome
<input type="text"/>	<input type="text"/>	<input type="text"/>

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Assessments: Psychosocial Factors – History of Abuse / Legal

### History of Abuse

(YES or NO)

Childhood  
(<17)

Adult  
(≥17)

Emotional

Physical

Sexual

Domestic Violence Observed in Childhood

Domestic Violence Adult Perpetrator

### Legal

Does the client have legal issues pending in any of the following areas? (YES or NO)

Divorce, Child Support or Custody

Housing, Employment or Health  
Care Discrimination

Immigration Status

Mental Health Commitment

Social Security Disability or SSI

DUI

Other

Is the client currently on parole or  
probation?

How much combined time has the  
client spent in jail or prison (Total  
Months)?

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Assessments: Psychosocial Factors – Diagnostic Impression and Mental Health History

### Diagnostic Impression and Mental Health History

Anxiety Symptoms

Depressive Symptoms

Personality Symptoms

Psychotic Symptoms

Substance Use

Mild  
Moderate  
Severe  
None  
Unknown

Affecting Risk

Not Affecting Risk

How would you describe the client's current drug/alcohol use?

Recreation user  
Heavy user  
Dependent user  
Non-user  
Unknown

Psychiatric History?

 Yes / No

If yes, specify:

History of Drug Treatment?

 Yes / No

If yes, specify:

Current Psychiatric Medications?

 Yes / No

If yes, specify:

History of Psychiatric Hospitalization?

 Yes / No

If yes, specify:



# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_


## Risk & Assessments: Assessments: Functional Status / Quality of Life

### Quality of Life Section 1

As of Date  

Staff

1. In general, would you say your health is:

 Excellent  
Very Good  
Good  
Fair  
Poor  
Unknown

2. Please select the option that best describes whether each of the following statements is true or false for you.

a. I am somewhat ill.



b. I am as healthy as anybody I know.



c. My health is excellent.



d. I have been feeling bad lately.



Definitely True  
Mostly True  
Don't Know  
Mostly False  
Definitely False  
Unknown

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Quality of Life Section 2

select the option for the one answer that comes closest to the way you have been feeling during the past month:

3. How much of the time, during the past month, has your health limited your social activities (like visiting with friends or close relatives)?

4. How much of the time, during the past month:

a. Have you been a very nervous person?

b. Have you felt calm and peaceful?

c. Have you felt downhearted and blue?

d. Have you been a happy person?

e. Have you felt so down in the dumps that nothing could cheer you up?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time
- Unknown

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Quality of Life Section 3

select the option for the one answer that comes closest to the way you have been feeling during the past month:

5. How often during the past month:

a. Did you feel full of pep?

b. Did you feel worn out?

c. Did you feel tired?

d. Did you have enough energy to do the things you wanted to do?

e. Did you feel weighed down by your health problems?

f. Were you discouraged by your health problems?

g. Did you feel despair over your health problems?

h. Were you afraid because of your health?

i. Did you feel overwhelmed by the number and frequency of HIV medication you have to take each day?

All of the time  
Most of the time  
A good bit of the time  
Some of the time  
A little of the time  
None of the time  
Unknown

6. How has the quality of your life been during the past month? That is, how have things been going for you?

Very well could hardly be better  
Pretty good  
Good and bad parts about equal  
Pretty bad  
Very bad could hardly be worse  
Unknown

7. How would you rate your physical health and emotional condition now compared to a month ago?

Much better  
A little better  
About the same  
A little worse  
Much worse  
Unknown

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

**Risk & Assessments: Assessments: Behavioral Risk**

Client Name: \_\_\_\_\_

## Behavioral Risk Section 1

As of Date  

Staff

In the past 3 months, have you... (YES or No)

Been homeless?

Been in alcohol or drug treatment?

Had sex while high on drugs or alcohol?

Had sex to get money, drugs, shelter, etc?

Paid for sex with money or drugs?

Had sex with a person who injects drugs?

Had sex with a man who has sex with men?

Been diagnosed with Hepatitis C?

Have you... (YES or No)

Ever injected drugs?

Ever been in alcohol or drug treatment?

Ever has sex against his/her will?

Ever had sex with other men (men only)?

Are you now pregnant now? (women only)

Been diagnosed with a sexually transmitted disease  
(e.g., Syphilis, Chlamydia, Gonorrhea, Hepatitis B?)

Been in the correctional system? (Probation, parole,  
secured detention, juvenile corrections, etc.)

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Behavioral Risk Section 2

In the past 3 months, have you had vaginal, oral or anal sex?  Yes / No

If Yes, with a...

Man?  Yes / No

If Yes, how many men?

Woman?  Yes / No

If Yes, how many women?

Transgender?  Yes / No

If Yes, how many transgender?

In the past 3 months, which types of sex have you had, and how often did you or your partner use condoms or barriers for each type of sex?

Had vaginal sex?

Performed anal sex? (top)

Received anal sex? (bottom)

Performed oral sex?

Received oral sex?

- No
- Yes, Always (4 out of 4 times)
- Yes, Usually (3 out of 4 times)
- Yes, Sometimes (2 out of 4 times)
- Yes, Occasionally (1 out of 4 times)
- Yes, Never (0 out of 4 times)
- Unknown

In the past 3 months, have you had unprotected anal or vaginal sex with someone...

Who was HIV Positive (has HIV)?  Yes / No

If Yes, how many partners?

Who was HIV Negative?  Yes / No

If Yes, how many partners?

Whose HIV status you did not know?  Yes / No

If Yes, how many partners?

Do you have a spouse or main partner?  Yes / No

If yes, for how long?  Years  Months

Is your partner? 

- HIV Positive
- HIV Negative
- Client doesn't know
- Unknown

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Behavioral Risk Section 3

In the past 30 days, have you used any of the following non-injected drugs?  Yes / No

If Yes, have you used the following drugs?

	Yes / No	If Yes, how many times in the past 30 days?
Crack	<input type="text"/>	<input type="text"/>
Cocaine	<input type="text"/>	<input type="text"/>
Heroin	<input type="text"/>	<input type="text"/>
Amphetamines (speed, crystal)	<input type="text"/>	<input type="text"/>
Amyl Nitrate (poppers)	<input type="text"/>	<input type="text"/>
Party drugs (Ecstasy, Special K, GHB)	<input type="text"/>	<input type="text"/>
Marijuana	<input type="text"/>	<input type="text"/>
5 or more alcoholic drinks (in one sitting)	<input type="text"/>	<input type="text"/>
Other: <input type="text"/>	<input type="text"/>	<input type="text"/>

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Behavioral Risk Section 4

In the past 30 days, have you injected any drugs or medication?

 Yes / No

If yes, have you injected any of the following drugs or medications?

If Yes, how many times in the past 30 days?

	Yes / No	
Heroin	<input type="text"/>	<input type="text"/>
Cocaine/Crack	<input type="text"/>	<input type="text"/>
Amphetamines (speed, crystal)	<input type="text"/>	<input type="text"/>
Steroids	<input type="text"/>	<input type="text"/>
Insulin	<input type="text"/>	<input type="text"/>
Hormones	<input type="text"/>	<input type="text"/>
Prescription drugs (codeine, morphine)	<input type="text"/>	<input type="text"/>
Other: <input type="text"/>	<input type="text"/>	<input type="text"/>

If you have injected drugs in the past 30 days, what kind of needles did you use?

In the past 30 days, have you shared needles with someone...

	Yes / No
New	<input type="text"/>
Bleached	<input type="text"/>
Shared (someone used before me)	<input type="text"/>
Shared (someone used after me)	<input type="text"/>
Reused my own	<input type="text"/>
Origin Unknown	<input type="text"/>

	Yes / No
Who was HIV positive (has HIV)	<input type="text"/>
Who was HIV negative	<input type="text"/>
Whose HIV status you didn't know	<input type="text"/>


# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Assessments: Barriers to Care Barriers to Care

Assessment Date    
Bridge Worker

Date of first HIV-positive test (auto-filled)   
Date dropped out of HIV medical care    
Current or former EIP client

- Financial barriers**
- Not enough money
  - No health insurance/not enough health insurance
  - Could not afford time off from work
  - Other money-related reasons (specify)

- Health barriers**
- Felt too sick to go
  - Felt too depressed to go
  - Disability prevented going
  - Drug or alcohol use prevented going
  - Other health-related reason (specify)

- Clinic/Facility barriers**
- Didn't know where to go to get care
  - Clinic was inconvenient (location, hours, etc.)
  - Clinic staff didn't speak client's language
  - Clinic staff was rude/unkind
  - Clinic waiting time was too long
  - Unable to get appointment/appoint offered too far in future
  - Clinic rules required abstinence and/or drug testing
  - Other clinic/facility-related reasons (specify)

- Housing/Responsibility barriers**
- Unable to get childcare
  - Unable to get time off from work
  - Needed to care for an adult family member or friend
  - Homeless
  - In jail or prison
  - Other reasons related to housing or responsibilities

### Knowledge/belief barriers

- Didn't want to think about being HIV+
- Dislike of doctors/clinics
- Didn't believe they were infected with HIV
- Didn't feel sick
- Believed HIV medication wouldn't help
- Believed HIV treatment would be unpleasant or painful
- Too embarrassed or ashamed to go for medical care
- Didn't want anyone to know they were HIV-positive
- Other reasons related to knowledge or beliefs (specify)



# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Assessments: Substance Abuse and Mental Illness Symptoms Screener (SAMISS)

### SAMISS Assessment Part 1

As of Date

\*

Staff

#### Substance Abuse

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times/mo
- 2-3 times/wk
- 4 or more times/wk
- Unknown

2. How many drinks do you have on a typical day when you are drinking?

- None
- 1 or 2
- 3 or 4
- 5 or 6
- 7-9
- 10 or more
- Unknown

3. How often do you have 4 or more drinks on 1 occasion?

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?

6. In the past year, how often did you drink or use drugs more than you meant to?

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- Unknown

Refer to Substance Abuse Treatment

(auto-fills)

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## SAMISS Assessment Part 2

### Mental Health

Yes / No

8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?

9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?

10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?

11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?

13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?

14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?

If yes, please explain

15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?

If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?

16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?

Refer to Mental Health Counseling

(auto-fills)

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Risk & Assessments: Assessments: Risk Reduction Screening

Screening Date \*  

Screening Tool

Outcome

## Care Plan: Needs Assessment

Program  (e.g. Ryan White, Bridge, HOPWA, etc)

Dated  


Category	Create			Create	
	Need	Care Plan		Need	Care Plan
Outpatient/Ambulatory Medical Care	<input type="radio"/>	<input type="checkbox"/>	Pediatric Dev Assessment/Early Interv Srv	<input type="radio"/>	<input type="checkbox"/>
AIDS Pharmaceutical Assistance (local)	<input type="radio"/>	<input type="checkbox"/>	Emergency Financial Assistance	<input type="radio"/>	<input type="checkbox"/>
Oral Health Care	<input type="radio"/>	<input type="checkbox"/>	Food Bank/Home-Delivered Meals	<input type="radio"/>	<input type="checkbox"/>
Early Intervention Services (Parts A and B)	<input type="radio"/>	<input type="checkbox"/>	Health Education/Risk Reduction	<input type="radio"/>	<input type="checkbox"/>
Health Insurance Premium and Cost Sharing Assistance	<input type="radio"/>	<input type="checkbox"/>	Housing Services	<input type="radio"/>	<input type="checkbox"/>
Home Health Care	<input type="radio"/>	<input type="checkbox"/>	Legal Services	<input type="radio"/>	<input type="checkbox"/>
Home and Community-Based Health Services	<input type="radio"/>	<input type="checkbox"/>	Linguistic Services	<input type="radio"/>	<input type="checkbox"/>
Hospice Services	<input type="radio"/>	<input type="checkbox"/>	Medical Transportation Services	<input type="radio"/>	<input type="checkbox"/>
Mental Health Services	<input type="radio"/>	<input type="checkbox"/>	Outreach Services	<input type="radio"/>	<input type="checkbox"/>
Medical Nutrition Therapy	<input type="radio"/>	<input type="checkbox"/>	Permanency Planning	<input type="radio"/>	<input type="checkbox"/>
Medical Case Management (including Trt Adherence)	<input type="radio"/>	<input type="checkbox"/>	Psychosocial Support Services	<input type="radio"/>	<input type="checkbox"/>
Substance Abuse Services - Outpatient	<input type="radio"/>	<input type="checkbox"/>	Referral for Health Care/Supportive Services	<input type="radio"/>	<input type="checkbox"/>
Case Management (non-medical)	<input type="radio"/>	<input type="checkbox"/>	Rehabilitation Services	<input type="radio"/>	<input type="checkbox"/>
Child Care Services	<input type="radio"/>	<input type="checkbox"/>	Respite Care	<input type="radio"/>	<input type="checkbox"/>
Other Services			Substance Abuse Services - Residential	<input type="radio"/>	<input type="checkbox"/>
<input type="text"/>			Treatment Adherence Counseling	<input type="radio"/>	<input type="checkbox"/>

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_


## Care Plan: Care Plan – Need, Goal, Interventions

**Date Need Identified**  

**Staff**

**Program** 

- Ryan White
- Care Services Program (RW Part B)
- EIP
- Positive Changes
- Bridge Project
- LIFE
- TMP
- CMP
- MCWP
- CARE-HIPP
- HOPWA

**Date Completed**  

**Outcome** 

- Completed
- Pending
- Some Progress
- Cancelled
- Unfunded
- Not available in area
- Completed Substance Abuse Program

**Need**  **if other**

**Subneed**  **if other**

**Goal**

### Interventions

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date
<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/> 	<input type="text"/> 	<input type="text"/>	<input type="text"/>	<input type="text"/> 

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Care Plan: Referral: Referrals

Referral Date	<input type="text"/>		Outcome Date	<input type="text"/>
Program	<input type="text"/>	Ryan White	Outcome	<input type="text"/>
Primary Service	<input type="text"/>	Care Services Program (RW Part B)		Kept appointment
Secondary Service	<input type="text"/>	Bridge Project		No show
Refer To	<input type="text"/>	MCWP		Rescheduled appointment
(other)	<input type="text"/>	CARE-HIPP	Notes	<input type="text"/>
Target/Appt. Date	<input type="text"/>	HOPWA		
Follow-up Date	<input type="text"/>	MHMR		
PSC Code	<input type="text"/>	Planned Parenthood		
Reason	<input type="text"/>	HUD		
		Section 8		
		DHHS		
		County health department		
		Eye care		
		Food pantry		
		Alternative medicine		
		Faith-based organization		
		Compassionate Care		
		Public hospital		
		Private hospital		
		Clinic public		
		Clinic private		
		Hospital public		
		Hospital private		
		County indigent care		
		Physician		
		Dental		
		Medicaid transportation		
		Program		
		Other		

**For Referrals to TESTING:**

1. Input referral date
2. Leave Program line blank
3. Leave service lines blank
4. Refer To = "Other"
5. (other) = "Testing"
6. Input Target/Appt. Date

**Note:** Can add additional information after "Testing" such as "Testing at SB Clinic" as long as the entry begins with the word "Testing". Be certain to follow up (Outcome) to document whether the client actually got tested.

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Case Notes: Case Notes

Staff

Created

Type   
Initial Assessment  
Service Assessment  
Progress Note  
Client Update  
Crisis Note  
Case Conference

Activity Date

[New Note]

Category

characters (max 7,750)

Don't share

Legal  
Mental Health  
Substance Use  
Incident Report  
Adherence  
Administrative  
Client Contact  
Education/Training  
Employment  
Family/Social Support  
Dental  
Financial  
Health Education  
Housing  
Impressions  
Medical  
Nutrition  
Presenting Problem  
Risk Reduction

New Paragraph

Password to sign and seal note

# ARIES DATA FORMS

RWP Required Fields (if applicable) = Orange Boxes

Client Name: \_\_\_\_\_

## Services: Services

**Staff \***  **Site**   
**Date of Service \***  **Days to Next Service**  date   
**Contract Name \***  **Created Date**   
**Program \***   
**Primary Service \***   
**Secondary Service \***   
**Agency Subservice \***   
**Units of Service \***  @ \$  per  = \$  **Total**  
**Client Payment**  **CARE/HIPP Co-Payment \***   
**Actual Minutes Spent**   
**Service Notes**

\$ = Required for Dental/  
Oral Health Only

Required for annual case conference service entry. At a minimum, include date(s) communicated with service providers and client and each service provider's name, job title, and agency name.

**NEW CLIENTS:** Also remember to include data related to any new clients on this screen (see *Policy #9* for details):

Contract Name = New Client

Program = Ryan White

Primary Service = Other Services

Secondary Service = Other Services

Agency Subservice Categories (more than one may apply...requiring multiple entries)

1. HIV Pos in Last 12 Months

2. New Link – Unmet Need

3. Re-Linked – Unmet Need

4. New to Riv/SB Counties

5. New to RW Funded Services

6. New to Agency