



Resistance Testing Consultation Service

(Toll Free Fax) 866-499-2041

Please remove any and all identifying patient information from the documents being submitted. This includes: *names, addresses, phone numbers, and social security numbers.*
Note: As additional protection, our fax line is secure, encrypted, and confidential.

Your Name: _____

Your E-Mail Address: _____

Month and Day of Your Birth: _____

Last 4 Digits of Your Social Security Number (or any 4 digit number you choose): _____

Professional Discipline: Physician Physician Assistant Nurse practitioner Nurse
 Other: _____

Name of Your Principal Employer: _____

Is your employer funded by the Ryan White Program? Yes No

Zip Code of Your Principal Employment Setting: _____

Your Gender: M F

Your Ethnicity: _____

Are you of Hispanic, Latino/a, or Spanish origin? Yes No

Number of years you have been providing services to HIV-infected patients: _____

Your Estimated Number of HIV-Infected Patients
(Monthly Average)

- None
- 1-9
- 10-19
- 20-49
- 50+

Your Primary Function

- Care Provider/Clinician
- Case Manager
- Intern/Resident
- Other: _____

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Patient Insurance (Select All That Apply): Private Medicaid Medicare ADAP

Patient Gender: M F Patient Ethnicity: _____

Patient Age: _____ years

Patient Weight: _____ kg Patient Height: _____ ft _____ in

Is patient currently pregnant? Yes No Unknown (but pregnancy potential)

If yes, gestational weeks: _____

If patient is female and of child-bearing age, please indicate current method of birth control:

Tubal Ligation Abstinence Oral Estrogen-containing Contraceptive

Medroxyprogesterone Other: _____

Does the patient have any medication allergies? (If yes, please list and describe)

Current medications (include dose/frequency) patient is taking at present:

Current or past opportunistic infections/conditions (including dates):

Does the patient have any pertinent co-morbidities such as chronic hepatitis B or C infection or renal/hepatic insufficiency, anemia, neutropenia, history of pancreatitis, etc.? (If yes, please describe)

List any ARVs that you would not consider an option due to past adverse effects/other reasons:

Do you feel this patient is a candidate for injectable T-20 (Enfuvirtide, Fuzeon®)?

Yes No

If you feel that the patient is a candidate for abacavir, please confirm HLA-B*5701 results.

Pos Neg

Have you performed a Trofile™ test to assess for utility of the CCR5 antagonist maraviroc (Selzentry™)? Yes-results attached Yes-results pending No

Does the patient have access to investigational meds at your site or is patient willing/able to travel for investigational meds? (If yes, please explain below) Yes No

LABORATORY DATA:

Date: CD4: Viral Load:
 Date: WBC: ANC: HgB: SCr: ALT: AST:
 Nadir CD4: Date: Highest viral load: Date:
 (If you have a flow sheet that summarizes CD4/viral load /other labs, please fax along with this form.)

Attach all current and past resistance test reports **(including dates tests performed as well as regimen taken when resistance test performed)**. If you have evidence of other resistance mutations not documented in resistance test reports (e.g. reported in notes from prior provider), please indicate those here:

Past Antiretroviral Use: Please place an X in the box next to any ARV the patient has taken in the past. (If you have a flow sheet that summarizes past ARV regimens, please include with the fax.)

Drug	X	Drug	X
Zidovudine/Retrovir [®]	AZT	Nelfinavir/Viracept [®]	NFV
Stavudine/Zerit [®]	d4T	Saquinavir/Invirase [®] /Fortovase [®]	SQV
Tenofovir/Viread [®]	TDF	Indinavir/Crixivan [®]	IDV
Abacavir/Ziagen [®]	ABC	Ritonavir/Norvir [®]	RTV
Didanosine/Videx/Videx EC [®]	ddl	Amprenavir/Agenerase [®]	APV
Lamivudine/Epivir [®]	3TC	Fosamprenavir/Lexiva [®]	FPV
Emtricitabine/Emtriva [®]	FTC	Atazanavir/Reyataz [®]	ATV
Zalcitabine/Hivid [®]	ddC	Lopinavir/Ritonavir/Kaletra [®]	LPV/r
Trizivir [®]	AZT/3TC/ABC	Tipranavir/Aptivus [®]	TPV
Combivir [®]	AZT/3TC	Darunavir/ Prezista [®]	DRV
Epzicom [®]	3TC/ABC		
Truvada [®]	FTC/TDF		
Atripla [™]	EFV/FTC/TDF	Enfuvirtide/Fuzeon [®]	T-20, ENF
Nevirapine/Viramune [®]	NVP	Maraviroc/Selzentry [™]	MVC
Delavirdine/Rescriptor [®]	DLV		
Efavirenz/Sustiva [®]	EFV	Raltegravir/Isentress [™]	RAL
Etravirine/Intelence [™]	ETR	Elvitegravir (GS-9137)	
Rilpivirine (TMC278)			

Please fax all information to our secure, encrypted, and confidential, toll-free, fax number at 866-499-2041.

****REMEMBER TO REMOVE ANY PATIENT IDENTIFYING INFORMATION PRIOR TO SENDING****

We will acknowledge receipt of this form within 48 hours and a member of our faculty will respond with detailed recommendations within 7-10 days. Some consults require extensive time to gather information regarding treatment options for the patient (particularly for pediatric patients). It would be helpful to know when the patient is planning to return to your clinic to discuss or start a next regimen.

Return appointment date: _____

Please provide your phone/and or pager number: _____,

as well as the best time to reach you: _____.

We are interested in receiving your feedback on this service. Would you be willing to be contacted for your feedback following this consultation? [] Yes [] No