Urban League
of Portland

African American HIV Services Navigation
REFERRAL FORM

Referral Source: **Date of referral:**

Client Information

Last Name: _____ **Middle**_____

First Name: _____ **Alias:** _____

Address:_____

City/State: _____ **ZIP:**_____

County: _____

Phone 1: (____) _____

Ok to Leave Msg? Yes No

Phone 2: (____) _____

Ok to Leave Msg? Yes No

Email: _____

Ok to Leave Msg? Yes No

Race/Ethnicity:
Hispanic/Latino African American/Black American Other
Indian/Alaska Native Asian White
Native Hawaiian/Pacific Islander

DOB: ____/ ____/ ____ **DOB estimated** ❑

Gender: Female Male Trans ____ Other

Are there children in family? Yes No

 # in Household: _____ **Household income:** _____

% of Federal Poverty Level: _____

Primary Language: _____

In HIV medical care? Yes No

HIV Case Manager: _____

HIV Care Provider: _____

Insurance: _____

Secondary insurance: _____

Veteran Yes No

Ryan White Eligibility determination date _____

Primary Issues of Concern/Needs (*circle all that apply*): Newly Diagnosed Out of Care for ≥ 6 months Other
Releasing from Prison/Jail A/D Dental Food Housing Mental Health Medical Sexual Health

Please provide a brief narrative of client needs: _____

_____

_____

_____

_____

_____ _____

Please return referral form to: Lamar Tillman, Community Health Program Manager
e: ltillman@ulpdx.org p: 503.280.2600 ext.608