



# Sample Peer Contact Form

Client Code: \_\_\_\_\_ Peer Code: \_\_\_\_\_ Date of Contact: \_\_\_/\_\_\_/\_\_\_

<b>Description of the contact</b> <i>Please check the appropriate item</i>		
<p><b>Who initiated contact?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Client</li> <li><input type="checkbox"/> Peer</li> <li><input type="checkbox"/> Other individual</li> </ul>	<p><b>Life Stressors Addressed:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Health</li> <li><input type="checkbox"/> Anxious/depressed/lonely</li> <li><input type="checkbox"/> Benefits/Insurance</li> <li><input type="checkbox"/> Problems with partner/kids</li> <li><input type="checkbox"/> Money</li> <li><input type="checkbox"/> Housing</li> <li><input type="checkbox"/> Family's Health</li> <li><input type="checkbox"/> Death of family/friend</li> <li><input type="checkbox"/> Legal problems</li> <li><input type="checkbox"/> Any accident</li> <li><input type="checkbox"/> Isolation</li> <li><input type="checkbox"/> Immigration issues</li> <li><input type="checkbox"/> Other (Explain)</li> </ul> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Incentive Provided:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><b>Did you talk about adherence?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><b>Did the client say she/he is adherent?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><b>Did you discuss T-cells or viral load?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>
<p><b>Where?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unsuccessful contact</li> <li><input type="checkbox"/> Phone contact</li> <li><input type="checkbox"/> ID clinic</li> <li><input type="checkbox"/> Street</li> <li><input type="checkbox"/> Hospital wards</li> <li><input type="checkbox"/> Drug program</li> <li><input type="checkbox"/> Client's home</li> <li><input type="checkbox"/> Other location</li> </ul>	<p><b>Type of contact:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Face to face</li> <li><input type="checkbox"/> Phone</li> <li><input type="checkbox"/> Mail</li> <li><input type="checkbox"/> Left message only</li> <li><input type="checkbox"/> Phone, but no answer</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b>Did the client mention missed days or med holidays?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p><b>If the client has missed meds, about how many days?</b></p> <p>_____days</p>
<p><b>Who was contacted?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Client</li> <li><input type="checkbox"/> Family/Friends</li> <li><input type="checkbox"/> Case Worker</li> <li><input type="checkbox"/> Medical</li> <li><input type="checkbox"/> Other</li> <li><input type="checkbox"/> Not applicable</li> </ul>	<p><b>Referrals made:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Case Manager</li> <li><input type="checkbox"/> Health Educator</li> <li><input type="checkbox"/> Medical Provider</li> <li><input type="checkbox"/> Support group</li> <li><input type="checkbox"/> Mental Health</li> <li><input type="checkbox"/> Supplies (food, baby, etc.)</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Notes and next steps:</b></p>

Next Visit: \_\_\_/\_\_\_/\_\_\_