Patient Label

Metro PrEP Referral

Email: MetroPrEP1@nashville.gov
Fax: 615-340-5648

REFERRING PROVIDER/AGENCY INFORMATON:

Referral Date: _____ **Referring Provider/Agency:** _____

Client Information

Name:			DOB:		
Address:			Phone:		
Insurance:			Email:		
Race:	American Indian/Alaska Native Black or African American Native Hawaiian /Pacific Islander	White Multi-Race Declined to Answer	Ethnicity:	Hispanic/Latino Not Hispanic Declined to Answer	
Gender Identity:			Sexual Orientation:		

Please select all that apply:

- ◯ HIV+ Partner
- ◯ STI+ in the last 6 mo
- ◯ Condomless Sex/Anticipates
- ◯ IVDU/Partner uses IVD
- ◯ Multiple Partners
- ◯ History of Transactional sex

Referral Notes:

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health