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| **Client Name:**  | **Client ID:**  |
| **CTR – PART A – Client Info** |
| **Program Performing Intake:**  |  **Site:** | **Counselor:** |
| **How Provided:** 🞅 In-person 🞅 Self-Test with result 🞅 Self-Test without result 🞅 No Test Provided  |
| **Session Date: \_ \_/\_ \_/\_ \_ \_ \_**□ No Testing was provided | **This encounter was part of a testing strategy (choose one):** |
| □ **Social Networking?**  | Referred by |
| □ **Testing Together?**  | Testing with |
| **HIV/AIDS Risk History**  |
| **Have you had sex with?**  | **In the last 5 years:** | **In the last 6 months:** | If Yes, select all that apply | Sex without a condom?  |
| **Women** | 🞅 No 🞅 Yes🞅 Chose not to respond/Unknown | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 Vaginal 🞅 Anal 🞅 Oral | 🞅 Yes 🞅 No |
| **Men** | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 Vaginal 🞅 Anal 🞅 Oral | 🞅 Yes 🞅 No |
| **Transgender women** | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 No 🞅 Yes🞅 Chose not to respond/Unknown | 🞅 Vaginal 🞅 Anal 🞅 Oral | 🞅 Yes 🞅 No |
| **Transgender women** | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 Vaginal 🞅 Anal 🞅 Oral | 🞅 Yes 🞅 No |
| **Gender non-conforming, non-binary, or questioning persons** | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | 🞅 Vaginal 🞅 Anal 🞅 Oral | 🞅 Yes 🞅 No |
| **Were any of your partners in the last 6 months…** |
| A person who is living with HIV? | 🞅 No 🞅 Yes 🞅 Choose not to respond/Unknown | A person who engages in sex in order to get something they need such as money, drugs, food or housing? | 🞅 No 🞅 Yes🞅 Choose not to respond/Unknown |
| A person who is living with HCV? | 🞅 No 🞅 Yes 🞅 Choose not to respond/Unknown |
| A person diagnosed with an STI? | 🞅 No 🞅 Yes 🞅 Choose not to respond/Unknown | A person who injects drugs? | 🞅 No 🞅 Yes 🞅 Choose not to respond/Unknown |
| **Have you in the last 6 months…** |
| Been diagnosed with an STI? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | Had sex in order to get something you needed such as money, drugs, food, or housing? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown  |

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| **Have you ever…** |
| Heard of PrEP? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | If Yes - on PrEP the last 12 months? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown |
| If yes – currently on PrEP  | 🞅 No 🞅 Yes  |

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| **Have you ever…** |
| Injected drugs | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown  | If Yes – within last 5 years? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown |
| If Yes – within last 12 months? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown |
| Had a previous HIV Test? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | If Yes, Date & result Date: \_ \_/\_ \_/\_ \_ \_ \_ | 🞅 Positive 🞅 Negative 🞅 Chose not to respond/Unknown |
| Been diagnosed with a Hemophilia/coagulation disorder? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | If Yes, received products prior to 1987? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown |
| Received a blood product or transplant? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown | If Yes, prior to 1992? | 🞅 No 🞅 Yes 🞅 Chose not to respond/Unknown |

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| **Client Name:** | **Client ID:** |
| **CTR - PART B – HIV Tests** |
| **Test 1 (Rapid)** | **Test 2 (Laboratory Testing)** |
| **Specimen Date:**  | **Specimen Date:**  |
| **Test Election:** ○ Anonymous ○ Confidential | **Test Election:** ○ Anonymous ○ Confidential |
| Test Results:○ Preliminary Positive ○ Negative ○ Invalid |  Lab-based Test Results:○ HIV-1 Positive○ HIV-1 Positive, possibly acute○ HIV-2 Positive○ HIV-2 Positive, undifferentiated | ○ HIV-1 Negative, HIV-2 Inconclusive ○ HIV-1 Negative○ HIV Negative○ Inconclusive  |
| Results Provided? ○ No ○ Yes  | If Yes, Date: (mm/dd/yyyy)  | Results Provided? ○ No ○ Yes○ Yes, from another agency | If Yes, Date: (mm/dd/yyyy) |
| Test ID/Accession:  | Test ID/Accession:  |
| **If the Final Result is Negative (Rapid or Laboratory Test)** |
| For clients who are currently not on PrEP…  |  |
|  Screened for PrEP Eligibility? | ○ No ○ Yes | *PrEP should be offered to individuals, including adolescents (weighing at least 77 lbs.), that do not have, but are at increased risk of acquiring HIV.* |
|  Eligible for PrEP? | ○ No ○ Yes | Referred to a PrEP Provider? | ○ No ○ Yes |
| Assistance with Linkage to a PrEP Provider?  | ○ No ○ Yes |
| **Support Services for Clients with a Negative Test Result** |
|  | Screened for need | Need Identified | Service Provided | Service Referred |
| Health benefits navigation and enrollment | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| Evidence-based risk reduction intervention | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| Behavioral health services (mental health treatment, and substance use treatment) | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |  ○ No ○ Yes |
| Social services (housing, transportation, domestic violence intervention and employment) | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| Notes: |
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| **Client Name:** | **Client ID:** |
| **CTR - PART D: If the Final Laboratory Test Result is Positive** |
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| **Did the client attend an HIV medical care appointment after this positive test?** | ○ Yes, confirmed  | If yes, date attended: (mm/dd/yyyy)  |
| ○ Yes, client/patient self-report  |
| ○ No |
| ○ Don’t know |
| **Has the client ever had a positive HIV test?** | ○ No ○ Yes ○ Don’t know | If yes, date of first positive result: (mm/dd/yyyy) | *If the day is Unknown, use the 15th of the month.* *If the month and day are Unknown, use 01/15.* *If the complete date is Unknown, use 01/01/1800.* |
| If yes, has the client seen a medical provider for ART in the past 6 months? | ○ No ○ Yes |
| **Was the client provided with individualized behavioral risk-reduction counseling?** | ○ No ○ Yes |
| **Was the client’s contact information provided to the health department for Partner Services?** | ○ No ○ Yes |
| **Was the NYS Provider Reporting Form DOH-4189 completed and submitted? (Required)** | ○ No ○ Yes |
| **What was the client’s most unstable housing status in the past 12 months?** | ○ Literally homeless ○ Unstably housed or at risk of losing housing ○ Stably housed ○ Declined to answer○ Don’t know |
| **Is the client pregnant?** | ○ No ○ Yes \*\*○ Declined to answer ○ Don’t know ○ Not asked   | **If yes:** **Is the client in prenatal care?** | ○ Yes ○ No ○ Don’t ○ Declined to answer  |
| **Was the client screened for need of perinatal HIV service coordination?** | ○ No ○ Yes |
| **Does the client need perinatal HIV service coordination?** | ○ No ○ Yes |
| **Was the client referred for perinatal HIV service coordination?** | ○ No ○ Yes |
| **Support Services for Clients with a Confirmed Positive Result** |
|  | **Screened for Need** | **Need Identified** | **Service Provided** | **Service Referred** |
| **Navigation services for linkage to HIV medical care** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Linkage services to HIV medical care** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Medication adherence support** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Health benefits navigation and enrollment** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Evidence-based risk reduction intervention** | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Behavioral health services** (mental health treatment, and substance use treatment) | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Social services** (housing, transportation, domestic violence intervention and employment) | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| **Notes:** |
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