HIV/HCV TEST FORM
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 60087 (Rev. 7/2019)

Session Date: _____

Site ID: _____

CTR Site Information

Site Type:	☐ CTR ☐ School ☐ Shelter ☐ Outreach ☐ Corrections ☐ Public Place ☐ Substance Abuse Treatment Facility ☐ Community Health Center ☐ Health Department

Client's Demographics

First Name	*Last Name*	*Birth Date*	*Country of Birth*

Street Address	*City*	*County*	*State*	*Zip Code*	*Phone Number*

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	*Race:* ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused ☐ Not Specified
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Transgender Unspecified ☐ Another Gender ☐ Refused	*Assigned Sex at Birth:* ☐ Male ☐ Female
Insurance Status: ☐ Private ☐ Medicare ☐ Medicaid ☐ Medicaid Expansion ☐ No Insurance ☐ Other ☐ Unknown	
Was Client Billed for HIV Test? ☐ Yes ☐ No	*Was Client Billed for Hepatitis C Test?* ☐ Yes ☐ No

Previous HIV Testing

Has Client Been Previously Tested for HIV? ☐ Yes ☐ No ☐ Unknown	*If yes, Date Tested:* ___/___/____
If yes, Reported Test Results: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown ☐ Refused ☐ Preliminary Positive	

Previous HCV Testing

Has Client Been Previously Tested for HCV? ☐ Yes ☐ No ☐ Unknown	*If yes, Date Tested:* ___/___/____
If yes, Reported Test Results: ☐ HCV Antibody Positive ☐ HCV Antibody Negative ☐ HCV Positive ☐ HCV RNA Positive ☐ HCV RNA Negative ☐ Unknown	

HIV & Hepatitis C Test Information

HIV Test Information		*HIV Confirmatory Test*		*HCV Test Information*		*HCV Confirmatory Test*	
Collection Date: ____/____/____		Collection Date: ____/___/___		Collection Date: ___/____/____		Collection Date: ___/___/____	
Worker:		If rapid reactive, did client provide a confirmatory sample?	☐ Yes ☐ Refused ☐ Could Not Locate ☐ Referred	Worker:		If rapid reactive, did client provide a confirmatory sample?	☐ Yes ☐ Refused ☐ Could Not Locate ☐ Referred
Test Technology:	☐ Conventional ☐ Rapid	Test Result:	☐ Positive ☐ Indeterminate ☐ Invalid ☐ Negative	Test Technology:	☐ Conventional ☐ Rapid	Test Result:	☐ RNA Positive ☐ RNA Negative ☐ Conf. Ab Pos.
Test Result:	☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Invalid			Test Result:	☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Invalid		
Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency	
Date Provided: ____/____/____		Date Provided: ____/____/____		Date Provided: ____/____/____		Date Provided: ____/____/____	
Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other

Check which infections the client was also tested for: ☐ **Chlamydia** ☐ **Gonorrhea** ☐ **Syphilis**
If not, why: ☐ **Patient Refused – Unable to Pay** ☐ **Patient Refused – Other** ☐ **Not Recommended by Provider** ☐ **Other**
For Chlamydia/Gonorrhea, please indicate which specimen sources were collected: ☐ **Urine/Vaginal** ☐ **Rectal** ☐ **Pharyngeal**

Viral Hepatitis Vaccine

Was hepatitis A and/or B vaccine given? ☐ Yes ☐ No	If yes, type of vaccine given: ☐ Hep A ☐ Hep B ☐ Twinrix
If no, why? ☐ Not at risk for HCV ☐ Facility doesn't offer vaccine ☐ Refer to Immunization Clinic ☐ Client indicated they were up to date ☐ Verified by provider to be up to date ☐ Private Vaccine Administered ☐ Refused Vaccine ☐ Outreach Event	

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Sexual Health History

1. Has client EVER reported having sex with a Male?	☐ No	☐ Yes	☐ Don't Know
In the past five years, did client report having sex with a Male?	☐ No	☐ Yes	
2. Has client EVER had sex with a Female?	☐ No	☐ Yes	☐ Don't Know
In the past five years, did client report having sex with a Female?	☐ No	☐ Yes	
3. Has client EVER had sex with an individual identifying as Transgender?	☐ No	☐ Yes	☐ Don't Know
In the past five years, did client report having sex with a Transgender?	☐ No	☐ Yes	
4. Did Client EVER Report Injection Drug Use?	☐ No	☐ Yes	☐ Don't Know
In the past 5 years, did client report Injection Drug Use?	☐ No	☐ Yes	
Has Client Ever Shared Equipment or Supplies While Injecting Drugs?	☐ No	☐ Yes	☐ Don't Know

Current Sexual Health Behaviors – Last 12 Months or Since Last Sexual Encounter Unless Otherwise Specified

1. The client's current sex partners are (Check All That Apply): ☐ Males ☐ Females ☐ Transgender Individuals ☐ Client has never had sex
2. How many individuals did the client have sex with in the **past 60 days**? ☐ 0 ☐ 1 – 2 ☐ 3 - 5 ☐ >5
3. How often does the client use condoms/other protection? ☐Always ☐Most of the Time ☐Not that Often ☐Never ☐ Client has never had sex or has not had sex in the past 12 months
4. What type of sex has the client had in the past 12 months or since the client's last CT/GC test? (Check All That Apply)

☐ No sex in past 12 months	☐ Vaginal Sex	☐ Oral Sex - Unspecified ☐ Anal Sex – Unspecified	☐ Oral Sex – Perform ☐ Anal Sex – Top	☐ Oral Sex - Receive ☐ Anal Sex - Bottom

5. Has the client used drugs in the past 12 months? ☐ Yes ☐ No ☐ Unknown

   If Yes: Methods of Drug Use (Check All That Apply): ☐ Inject ☐ Smoke ☐ Snort ☐ Ingest ☐ Unknown
6. Has the client had anonymous sex partners? (ex. used dating apps or met at bar) ☐ Yes ☐ No ☐ Unknown

Additional HIV Risk Factors - – Last 12 Months, Check all that apply.

☐ Exchange sex for drugs/money	☐ Sex with Person Living with HIV	☐ Victim of human/sex trafficking
☐ Sex with someone diagnosed with a STD	☐ Sex with someone who exchanges sex for drugs/money	☐ Had sex with a person who injects drugs
☐ Previously diagnosed with a STD	☐ Victim of sexual assault	☐ Patient requested testing
☐ Sex under influence of drugs or alcohol	☐ From Endemic HIV Region	
☐ Sex with multiple partners		

Additional HCV Risk Factors - – Last 12 Months, Check all that apply.

☐ Have HIV infection	☐ Mother had HCV infection	☐ Had sex with HCV infected individual
☐ Received blood clotting factors before 1987	☐ Family member HCV Positive	☐ Baby Boomer screening (born between 1945 & 1965)
☐ Received blood transfusion or organ transplant before 1992	☐ Receiving long-term hemodialysis	☐ Sex with a person who injects drugs
☐ Abnormal liver tests	☐ Received tattoos or body piercings in a non-sterile setting	☐ Patient requested testing

PrEP Awareness, Referrals and Eligibility Screening

1. Has the client ever heard of HIV PrEP?		☐ No	☐ Yes	
2. Has the client used PrEP anytime in the previous 12 months?		☐ No	☐ Yes	
Is the client currently taking HIV PrEP?		☐ No	☐ Yes	
3. Was the client screened for PrEP eligibility?	☐ No	☐ Yes		
Is the client eligible for a PrEP referral?	☐ No	☐ Yes, CDC Criteria	☐ Yes, Local Criteria	
Was the client referred to a PrEP provider?	☐ No	☐ Yes		
Was navigation or linkage services provided to assist with linkage to a PrEP provider?	☐ No	☐ Yes		

Essential Support Services – All Clients

1. Was the client assessed for **health benefits navigation and enrollment** needs?	☐ No	☐ Yes
Was the client identified as needing health benefits navigation and enrollment services?	☐ No	☐ Yes
Was the client provided or referred to services for health benefits navigation and enrollment services?	☐ No	☐ Yes
2. Was the client assessed for **evidence-based risk reduction intervention** needs?	☐ No	☐ Yes
Was the client identified as needing evidence-based risk reduction intervention services?	☐ No	☐ Yes
Was the client provided or referred to evidence-based risk reduction intervention services?	☐ No	☐ Yes
3. Was the client assessed for **behavioral health** service needs?	☐ No	☐ Yes
Was the client identified as needing behavioral health services?	☐ No	☐ Yes
Was the client provided or referred to behavioral health services?	☐ No	☐ Yes
4. Was the client assessed for **social services** needs?	☐ No	☐ Yes
Was the client identified as needing social services?	☐ No	☐ Yes
Was the client was provided or referred to social services?	☐ No	☐ Yes

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Additional Questions - Persons Diagnosed with HIV

1. Did client receive individualized behavioral risk reduction counseling?			☐ No	☐ Yes	
2. By client's self-report, what was the most unstable housing status experienced in the previous 12 months:			☐ Literally Homeless ☐ Stably housed ☐ Declined	☐ Unstably housed ☐ Not Asked ☐ Unknown	
3. Is the client pregnant?	☐ No	☐ Yes	☐ Not Asked	☐ Declined to Answer	☐ Unknown
Has the client received prenatal care during the pregnancy?	☐ No	☐ Yes	☐ Not Asked	☐ Declined to Answer	☐ Unknown

Essential Support Services – Persons Diagnosed with HIV

1. Was the client screened for the need of **navigation for linkage to HIV medical care**?	☐ No	☐ Yes
Was the client identified as needing navigation services for linkage to HIV medical care?	☐ No	☐ Yes
Was the client provided or referred to navigation services for linkage to HIV medical care?	☐ No	☐ Yes
2. Was the client screened for the need of **linkage services to HIV medical care**?	☐ No	☐ Yes
Was the client identified as needing linkage services to HIV medical care?	☐ No	☐ Yes
Was the client provided or referred for linkage services to HIV medical care?	☐ No	☐ Yes
3. Was the client assessed for **health benefits navigation and enrollment** needs?	☐ No	☐ Yes
Was the client identified as needing health benefits navigation and enrollment services?	☐ No	☐ Yes
Was the client provided or referred to services for health benefits navigation and enrollment?	☐ No	☐ Yes
4. Was the client assessed if they needed **medication adherence support services**?	☐ No	☐ Yes
Was the client identified to need medication adherence support services?	☐ No	☐ Yes
Was the client provided or referred to medication adherence support services?	☐ No	☐ Yes
5. Was the client assessed for **evidence-based risk reduction intervention** needs?	☐ No	☐ Yes
Was the client identified as needing evidence-based risk reduction intervention services?	☐ No	☐ Yes
Was the client provided or referred to evidence-based risk reduction intervention services?	☐ No	☐ Yes

Behavioral Health Services & Social Services – Persons Diagnosed with HIV

1. Was the client assessed for **behavioral health services** needs?	☐ No	☐ Yes
Was the client identified as needing behavioral health services?	☐ No	☐ Yes
Was the client provided or referred to behavioral health services?	☐ No	☐ Yes
2. Was the client assessed for **social services** needs?	☐ No	☐ Yes
Was the client identified as needing social services?	☐ No	☐ Yes
Was the client provided or referred to social services?	☐ No	☐ Yes