

HIV COUNSELING INFORMATION FORM

Unique Office of AIDS
Client Number

DC

Administrative Information

Counseling and Test Result

LHD/agency no.: Site no.:

Clinic type: (mark one) **Client's test election:** (mark one)

(01) Alternative test site (01) Yes, Tested anonymously
 (02) Family planning (02) Yes, Tested confidentially
 (03) STD (03) Yes, Court or other non-OA test
 (04) Alc./drug treatment (04) No, Not at risk
 (05) Detention facility (05) No, Tested recently
 (06) Primary care (06) No, Still in window period
 (07) HIV test (07) No, Concern with confidentiality
 (08) Street outreach (08) No, Disclosure not convenient
 (09) Mobile van (09) No, Does NOT want to know
 (10) TB (10) No, Other reason
 (11) Youth drop in (11) Test not offered
 (12) Other health dept.
 (13) Other, specify: _____

Counseling: (date and initial) _____ **Date Service Provided (mm/dd/yy)** _____ **Print Initials** _____

Risk Assessment Counseling: _____/_____/_____

Follow-up Contact: _____/_____/_____ (to reset missed disclosure sessions by confidential patients)

Disclosure Counseling: _____/_____/_____ Mark if post disclosure counseling scheduled.

Post Disclosure Counseling: _____/_____/_____

Test result: (mark one and initial) _____ **Initials** _____

(1) Positive (2) Negative (3) Inconclusive (carefully verify anonymous clients using *Client Information*)

Mark if oral test kit used. Mark if rapid test used.

Matching criterion:
Enter first letter of last name. Mark "*" if declined/refused.
First letter of last name:

Alternative billing: (mark all that apply)

No billing to OA
 Risk Assessment
 Disclosure
 Post Disclosure
 Laboratory Work

Client Information

HIV Testing History

Referrals

Race/ethnicity: (mark one or two)
1st (1) African American (not Hispanic)
 (2) American Indian/Alaskan Native
 (3) Asian/Pacific Islander
 (4) Hispanic/Latino(a)
 (5) White (not Hispanic)
 (6) Other, specify: _____

Date of birth: (mm/dd/yy)

Gender and pregnancy: (mark one)
 (1) Male
 (2) Female
 (3) Pregnant Female
 (4) Transgendered: Male to Female
 (5) Transgendered: Female to Male
 (6) Other, specify: _____

Residence county: _____

Residence zip code:

Mark if client is homeless.

Client was referred by: (mark one)
 (01) HIV+ partner
 (02) PCRS/partner notification
 (03) OA NIGHT outreach (incentive/referral)
 (04) Other outreach worker
 (05) HIV education program
 (06) AIDS telephone hotline
 (07) Other AIDS agency
 (08) Alcohol/drug treatment program
 (09) M.D./health clinic
 (10) Friend/relative
 (11) Media (TV, radio, print)
 (12) No identifiable referral source

Client's reason for testing: (mark one)
 (01) Reconfirming HIV+ result
 (02) Reports AIDS-like symptoms
 (03) Has current HIV+ partner
 (04) Had past HIV+ partner
 (05) TB diagnosis
 (06) STD related
 (07) Pregnancy
 (08) Risky behavior
 (09) Starting a new relationship
 (10) Just wanted to know
 (11) Other, specify: _____

Number of prior HIV tests: (circle one)
 (0) (1) (2) (3) (4) (5) (6) (7) (8) (9+)

Date of last test result: _____/_____/_____ (mm/yy)

Last test result: (mark one)
 (1) Positive
 (2) Negative
 (3) Inconclusive
 (4) Did not return for results

Risk Reduction Goals

Risk assessment stage of change: (mark one)
 (1) Not thinking about it (Precontemplation)
 (2) Thinking about it (Contemplation)
 (3) Ready for action (Preparation)
 (4) Action
 (5) Maintenance

Immediate risk reduction goal setting: (to be accomplished by client before disclosure)

At Disclosure: Risk reduction goal(s): (mark one)
 (1) No Goal Established at Risk Assessment
 (2) Client Made No Effort
 (3) Goal Attempted
 (4) Goal Achieved

Post Disclosure/Short term risk reduction goal(s):

Long term risk reduction goal(s):

Client referrals:
Record at risk assessment (RA), disclosure (D) and post disclosure (PD). Order by marking 1 for your primary referral. Other referrals should be numbered 2 and 3.

| | | | |
|---|----------|-----------|-----------------------------------|
| RA | D | PD | |
| _____ | _____ | _____ | (01) NONE |
| _____ | _____ | _____ | (02) Referral list only |
| Other Testing | | | |
| _____ | _____ | _____ | (03) CCS/HIV children's program |
| _____ | _____ | _____ | (04) Other testing |
| Risk/Harm Reduction | | | |
| _____ | _____ | _____ | (05) HIV education service |
| _____ | _____ | _____ | (06) Follow-up HIV counseling |
| _____ | _____ | _____ | (07) Prevention skill development |
| _____ | _____ | _____ | (08) Prevention support group |
| _____ | _____ | _____ | (09) Individual psychotherapy |
| _____ | _____ | _____ | (10) Alcohol/drug treatment |
| _____ | _____ | _____ | (11) Twelve step program |
| _____ | _____ | _____ | (12) Needle exchange program |
| HIV Positive and Other Referrals | | | |
| _____ | _____ | _____ | (13) EIP |
| _____ | _____ | _____ | (14) Medical services |
| _____ | _____ | _____ | (15) PCRS/partner notification |
| _____ | _____ | _____ | (16) Case management |
| _____ | _____ | _____ | (17) Crisis intervention |
| _____ | _____ | _____ | (18) TB |
| Other Services | | | |
| _____ | _____ | _____ | (19) STD clinic |
| _____ | _____ | _____ | (20) Family planning clinic |
| _____ | _____ | _____ | (21) Pregnancy evaluation/care |
| _____ | _____ | _____ | (22) Social services |
| _____ | _____ | _____ | (23) Domestic violence counseling |
| _____ | _____ | _____ | (24) Other, specify: _____ |

Counselor: Review/Assess Introductory Issues

Confidentiality/anonymity testing.
 Risk assessment process and purpose of form.
 What the HIV test measures.
 Meaning and accuracy of test results (positive, negative, inconclusive).
 Impact of HIV on the immune system.

Counselor: Review/Assess Testing Issues

Window period/date of any follow-up test.
 Process of testing.
 Coping with waiting for test results.
 Client's readiness to be tested.
 Offer testing, if appropriate.
 Encourage the client to return for results.

Counselor Notes: _____

Discuss and record the client's behavior during the **last two years** unless otherwise indicated. If client has received an HIV test result during the last two years then discuss and record the client's behavior since the date of the client's last test result.

Date of Last Test Result: (if within last 2 years) ____/____ (mm/yy) (from HIV Testing History on front of form)

Sexual Risk History (last 2 years/last result)

| | | |
|---|---|--|
| Total number of sex partners: (000-999) <input type="text"/> | | |
| Male sex partner(s). | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal insertive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| | <input type="checkbox"/> Anal receptive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| Female sex partner(s). | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal insertive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| Sex with sex worker(s)/prostitute(s). | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input checked="" type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal insertive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| | <input type="checkbox"/> Anal receptive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| Sex partner(s) who injected drugs or other substances. | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input checked="" type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal insertive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| | <input type="checkbox"/> Anal receptive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| HIV infected sex partner(s). | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input checked="" type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal insertive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| | <input type="checkbox"/> Anal receptive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> Mark <input checked="" type="checkbox"/> if client knew partner's HIV positive status prior to sexual contact. | | |
| (Females Only) Male partner(s) who has had sex with a male. | | |
| Partner(s): (mark one <input checked="" type="checkbox"/>) | Sexual activity: (mark all that apply <input checked="" type="checkbox"/>) | Frequency of barrier use: Never Sometimes Always |
| <input type="checkbox"/> (0) no partners | <input type="checkbox"/> Oral | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input checked="" type="checkbox"/> (1) one or more | <input type="checkbox"/> Vaginal | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |
| <input type="checkbox"/> (*) declined/refused | <input type="checkbox"/> Anal receptive | <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) |

Drug and Substance Use History (last 2 years/last result)

| | | | | |
|--|---|---|------------------------------|---|
| Drug and substance use. <input type="checkbox"/> (*) declined/refused | | | | |
| Drugs & substances used: (mark all that apply <input checked="" type="checkbox"/>) | Injected: (mark if yes) | Frequency used with sex: Never Rarely Sometimes Usually | | |
| <input type="checkbox"/> alcohol | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> marijuana | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> heroin, etc. | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> barbiturate | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> tranquilizers | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input checked="" type="checkbox"/> crack | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input checked="" type="checkbox"/> amphetamine | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input checked="" type="checkbox"/> cocaine | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input checked="" type="checkbox"/> nitrate/nitrite | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input checked="" type="checkbox"/> ecstasy | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> PCP | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> hallucinogens | | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| <input type="checkbox"/> other, specify: | <input checked="" type="checkbox"/> (1) yes | <input type="checkbox"/> (1) | <input type="checkbox"/> (2) | <input type="checkbox"/> (3) <input type="checkbox"/> (4) |
| Injected drugs or other substances. | | | | |
| Shared needles: (mark one <input checked="" type="checkbox"/>) | | Needle exchange: (mark one <input checked="" type="checkbox"/>) | | |
| <input type="checkbox"/> (1) Never | | <input type="checkbox"/> (1) Never | | |
| <input type="checkbox"/> (2) Sometimes | | <input type="checkbox"/> (2) Sometimes | | |
| <input type="checkbox"/> (3) Always | | <input type="checkbox"/> (3) Always | | |
| <input type="checkbox"/> Mark <input checked="" type="checkbox"/> if shared needles with a known HIV positive partner. | | <input type="checkbox"/> (4) Not available in client's area | | |
| Cleaned works: (mark one <input checked="" type="checkbox"/>) | | IDU treatment history: (mark one <input checked="" type="checkbox"/>) | | |
| <input type="checkbox"/> (1) Never | | <input type="checkbox"/> (1) Never | | |
| <input type="checkbox"/> (2) Sometimes | | <input type="checkbox"/> (2) Within last 2 years/last result | | |
| <input type="checkbox"/> (3) Always | | <input type="checkbox"/> (3) Prior to last 2 years/last result | | |
| Other Risk History (last 2 years/last result) | | | | |
| Hepatitis and STD History. <input type="checkbox"/> (*) declined/refused | | | | |
| STDs/Hepatitis : (mark all that apply <input checked="" type="checkbox"/>) | | | | |
| <input type="checkbox"/> no STDs/Hepatitis | | <input type="checkbox"/> genital/anal warts (HPV) | | |
| <input type="checkbox"/> syphilis (syph, the pox, lues) | | <input type="checkbox"/> genital herpes (HSV) | | |
| <input type="checkbox"/> gonorrhoea (GC, clap, drip) | | <input type="checkbox"/> hepatitis B (HBV) | | |
| <input type="checkbox"/> chlamydia | | <input type="checkbox"/> hepatitis C (HCV) | | |
| <input type="checkbox"/> trichomoniasis (trich) | | <input type="checkbox"/> other, specify: | | |
| Other risk factors. (mark <input checked="" type="checkbox"/> , if appropriate) Declined/refused | | | | |
| <input checked="" type="checkbox"/> Received money/other items or services for sex. | | | | <input type="checkbox"/> (*) |
| <input checked="" type="checkbox"/> Received drugs for sex. | | | | <input type="checkbox"/> (*) |
| <input type="checkbox"/> Behavior resulting in other blood to blood contact (SM, tattooing, piercing, cuts, etc.) or that allows blood contact with mouth, vagina or anus. | | | | <input type="checkbox"/> (*) |
| <input type="checkbox"/> Shared objects/fingers inserted in mouth, vagina or anus. | | | | <input type="checkbox"/> (*) |
| <input type="checkbox"/> Blood to blood exposure on the job. | | | | <input type="checkbox"/> (*) |
| <input checked="" type="checkbox"/> Job exposure blood known to be HIV+. | | | | <input type="checkbox"/> (*) |
| <input checked="" type="checkbox"/> Blood/blood product transfusion before 1985 (or in a country where blood is/was not tested for HIV). | | | | <input type="checkbox"/> (*) |
| <input checked="" type="checkbox"/> Child born of an HIV-infected woman. | | | | <input type="checkbox"/> (*) |
| <input type="checkbox"/> Other behavior, specify: _____ | | | | |

Optional Data

Item 1: _____
 Item 2: _____
 Item 3: _____
 Item 4: _____

Disclosure Counseling = MSM or Grey Box

Counselor: Review/Assess Drug and STD Issues

- Prevention/harm reduction/safer sex with IDUs.
- Demonstrate proper needle cleaning.
- Encourage and support substance abuse treatment and recovery.
- Alcohol/drug use with sex as co-factor for HIV risk.
- Other sexual behaviors affecting STDs (eg. rimming).
- Presence of STDs as a co-factor for HIV risk.
- Health effects of concurrent STD/HIV (e.g. pelvic inflammatory disease).

Counselor: Review/Assess Basic Issues

- Cultural/peer influences.
- Demonstrate proper condom & barrier use.
- Role-play with client to build needed skills.
- Discuss safer sex guidelines.
- Partner risks as they relate to client risk.
- Communication of HIV risk reduction with partner.
- Domestic violence/sexual assault.
- Voluntary PCRS/partner notification.
- Discuss obstacles to condom/barrier use.
- Pregnancy/maternal transmission (utero, birth, breastfeed).
- Integration of birth control and risk reduction.