Wyoming Department of Health – Communicable Disease HIV, Hepatitis and STD Risk Assessment

FACILITY INFORMATION

Today's Date: _____
Facility Name: _____
Facility Address: _____
Facility Phone number: _____
Client ID: _____

Client: Please complete pages one and two of this document. The following information will be helpful for your provider to determine proper screening and/or vaccination needs for this visit.

DEMOGRAPHICS

Patient Name: _____ DOB: _____ Age: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Email: _____
Preferred Method of Contact by Clinic: ☐ Phone ☐ Email ☐ Mail ☐ Other:
_____
Contact Restrictions: _____

Race (check all that apply): ☐ White ☐ Black/African American ☐ Native American/Alaskan Native ☐ Asian

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Don't know ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't know ☐ Decline to answer

Current Gender: ☐ Male ☐ Female ☐ Transgender (male to female) ☐ Transgender (female to male)

SEXUAL HEALTH AND HISTORY

Current gender of sex partner(s) and type of sex (check all that apply):
☐ Male: ☐ Oral (give/receive) ☐ Anal (give/receive) ☐ Vaginal
☐ Transgender (male to female) : ☐ Oral (give/receive) ☐ Vaginal ☐ Anal
☐ Female : ☐ Oral (give/receive) ☐ Vaginal ☐ Anal
☐ Transgender (female to male): ☐ Oral (give/receive) ☐ Anal (give/receive)
☐ Not currently sexually active
Please list the number of sexual partners you have had within the last 3 months:

Have you ever had an HIV test? ☐ Yes, result and date: _____ ☐ No
Have you been vaccinated for Hepatitis B? ☐ Yes, when?:_____ ☐ No
Have you been vaccinated for Hepatitis A? ☐ Yes, when? _____ ☐ No
Have you been vaccinated for HPV? ☐ Yes, when? _____ ☐ No

Do you know if you have recently been exposed to any STDs, HIV or Viral Hepatitis?
☐ Yes, specify disease and date: _____ (Contact type: Household/ needle share/ sexual/ blood exposure)_____ ☐ No
Have you had a positive STD, HIV, or Viral Hepatitis test in the past 12 months?
☐ Yes, specify disease and date:_____ ☐ No

Females:
Are you pregnant? ☐ Yes, due date: _____ ☐ Possibly ☐ No ☐ Unknown
Date of last pelvic exam/pap test: _____ ☐ Unknown

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Please select boxes pertaining to you (check all that apply)

☐ Injection drug use (even one time)
Type of drug(s):_____

☐ Condom Use:
With Main Partner:
- ☐ Always
- ☐ Sometimes
- ☐ Never

With Other Partner(s):
- ☐ Always
- ☐ Sometimes
- ☐ Never

With New Partner (within last 3 months):
- ☐ Always
- ☐ Sometimes
- ☐ Never

With Previous Partner:
- ☐ Always
- ☐ Sometimes
- ☐ Never

☐ Infected with HIV

☐ Born in Asia, Africa or South America

☐ Parents born in Asia, Africa or South America

☐ Current or history of hemodialysis

☐ Receiving chemotherapy or other immunosuppressive therapy

☐ Current or history of incarceration

☐ Current or history of homelessness

☐ History of prior STDs or Hepatitis

☐ History of working in a health care setting

☐ Consistently abnormal liver tests

☐ Mother positive for HIV, STDs, Hepatitis B or C

☐ Sex with:
- ☐ Anonymous Partner
- ☐ Partner met via internet

☐ Sex while:
- ☐ Intoxicated
- ☐ High
- ☐ In public

☐ Sex in exchange for:
- ☐ Drugs
- ☐ Money
- ☐ Food
- ☐ Shelter

☐ History of blood exposure (under skin or mucous membranes)

☐ Born between 1945-1965 (Baby Boomer)

☐ Recipient of clotting factor or blood concentrates prior to 1987

☐ Recipient of blood transfusions, blood components or organ transplants prior to 1992

☐ Tattoos, Date(s): _____
Type:
- ☐ Professional setting
- ☐ Unprofessional setting
- ☐ Other:_____

Symptoms (check all that apply):

☐ Yellowing of the skin

☐ Clay-colored stools

☐ Abnormal penile or vaginal discharge

☐ Penile, vaginal, anal or oral warts, sores or lesions

☐ Pain or burning with urination

☐ Increased frequency of urination

☐ Pain or bleeding with sexual intercourse

☐ Abdominal or pelvic pain

☐ Penile, vaginal, or rectal itching

☐ Abnormal bleeding

☐ Night Sweats

☐ Fever

☐ Rash, generalized or on hands/feet

☐ Other
List: _____

If you have selected any of these boxes, you are strongly encouraged by the Wyoming Department of Health to be tested for: STDs, HIV, and Viral Hepatitis.

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For Staff Use Only

Visit Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____

Areas to address with client	Check or comments
Confidentiality of records (HIPAA)	
Informed Consent (as needed)	
HIV/Hepatitis/STD disease transmission and education	
Identify personal risk behaviors and circumstances	
Offer condoms/dental dams/lube	
Expedited Partner Therapy (if applicable in clinic)	
Allergies	
Vaccinations	

Action Required	Comments
Develop Risk Reduction Plan if needed (specify plan)	
Referrals made (if applicable): If more than one referral has been made, please provide that information on a separate page	Clinic Name:_____ Provider Name: _____ Phone Number:_____ Reason:_____

Counseling and Testing

Testing and Results		
Date	**Test**	**Result (Circle One)**
	HIV rapid	Reactive / Non-reactive
	HIV confirmatory (if applicable)	Positive/Negative
	Chlamydia	Positive / Negative
	Gonorrhea	Positive/ Negative
	Syphilis (RPR)	Reactive (titer:_____) / Non-reactive
	Syphilis Confirmatory (FTA, TPPA, etc.)	Positive/Negative
	Hepatitis B Surface Antigen (HBsAg)	Positive / Negative
	Hepatitis B Core Antibody – Total (HBcAb-Tot)	Reactive / Non-reactive
	Hepatitis C antibody	Reactive / Non-reactive
	Hepatitis C RNA	Detected / Not Detected

Staff Signature: _____ Date:_____

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Positive Test Results

Post-Test Education	
Action	**Comments**
Risk reduction plan reviewed	
Need for follow up testing	
Follow up appointment if needed	
Updates on referrals	
Immunizations, Dates initiated:	Hep A:_____ Hep B:_____ Twinrix:_____ HPV:_____
HIV Services Program if positive	
Partner services	

All positive/reactive tests must be reported to the Wyoming Department of Health Communicable Disease Unit. Please report online through the Electronic Confidential Disease Report (ECDR) at **https://prismdata.health.wyo.gov/** or through the Patient Reporting Investigation Surveillance Manager (PRISM). **Date Reported: _____**

Client received results: Date _____ ☐ In person ☐ By Phone ☐ Certified Letter
☐ Unable to locate patient, provide justification: _____

Treatment

Client treated for: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Not treated, provide justification: _____
Medication provided: Date: _____ Time:_____ (am / pm)
Referral made for**:** ☐ HIV ☐ Hepatitis B ☐ Hepatitis C. Date: _____

Chlamydia		
☐ Azithromycin 1gm	☐ Doxycycline 100mg bid x 7d	☐ Other: _____

Gonorrhea		
☐ Ceftriaxone 250mg IM	**PLUS**	☐ Azithromycin 1gm PO
		OR
		☐ Doxycycline 100mg qd x 7d

Syphilis		
☐ Primary,Secondary, and Early Latent: Benzathine penicillin G 2.4mu IM		
☐ Latent > 1 year: Benzathine penicillin G 2.4mu IM x 3 doses at weekly intervals		
Dose 1 date:	Dose 2 date:	Dose 3 date:

Notes: _____
_____

Provider prescribing treatment: _____ _____
(Print name and credentials) (Signature)

☐ Medication instructions provided ☐ Disease information sheet provided

Partner Services

The Wyoming Department of Health Communicable Disease Unit Clinic Interview may be used as a reference for Partner Services

Name: _____ DOB: _____
Address: _____
Email: _____ Phone number: _____
Partner Treated: ☐ Yes, date and treatment provided: _____
☐ No, provide justification: _____
EPT Provided: ☐ Yes, date and treatment provided: _____
☐ No, provide justification: _____

Staff Signature: _____ Date: _____