

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: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Other:
Contact Restrictions: _____
Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer
Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (male to female) <input type="checkbox"/> Transgender (female to male)

SEXUAL HEALTH AND HISTORY

Current gender of sex partner(s) and type of sex (check all that apply): <input type="checkbox"/> Male: <input type="checkbox"/> Oral (give/receive) <input type="checkbox"/> Anal (give/receive) <input type="checkbox"/> Transgender (male to female): <input type="checkbox"/> Oral (give/receive) <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Female: <input type="checkbox"/> Oral (give/receive) <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Transgender (female to male): <input type="checkbox"/> Oral (give/receive) <input type="checkbox"/> Anal (give/receive) <input type="checkbox"/> 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? <input type="checkbox"/> Yes, result and date: _____	<input type="checkbox"/> No
Have you been vaccinated for Hepatitis B? <input type="checkbox"/> Yes, when?: _____	<input type="checkbox"/> No
Have you been vaccinated for Hepatitis A? <input type="checkbox"/> Yes, when?	<input type="checkbox"/> No
Have you been vaccinated for HPV? <input type="checkbox"/> Yes, when?	<input type="checkbox"/> No
Do you know if you have recently been exposed to any STDs, HIV or Viral Hepatitis? <input type="checkbox"/> Yes, specify disease and date: _____ (Contact type: Household/ needle share/ sexual/ blood exposure) _____ <input type="checkbox"/> No	
Have you had a positive STD, HIV, or Viral Hepatitis test in the past 12 months? <input type="checkbox"/> Yes, specify disease and date: _____ <input type="checkbox"/> No	
Females: Are you pregnant? <input type="checkbox"/> Yes, due date: _____ <input type="checkbox"/> Possibly <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of last pelvic exam/pap test: _____ <input type="checkbox"/> Unknown	

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)
- Sexual Assault
- 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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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

<input type="checkbox"/> Ceftriaxone 250mg IM	PLUS	<input type="checkbox"/> Azithromycin 1gm PO
		OR
		<input type="checkbox"/> 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:** _____