COMMUNICABLE DISEASE RISK ASSESSMENT

FACILITY INFORMATION

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

Client: Please fill out the first two pages. This will help your provider select the rights tests or vaccinations for you.

DEMOGRAPHICS

Patient Name: _____ **DOB:** _____ **Age:** _____
Address: _____ **City:** _____ **Zip:** _____
Phone: _____ Email: _____
How should we contact you? ☐ Phone ☐ Email ☐ Mail ☐Other: _____
Contact Restrictions: _____**Medicaid:** ☐ **Insurance:** ☐ **No Insurance:** ☐

How did you hear about us?
☐ Knowyo.org ☐ Poster ☐ Word of mouth ☐ Radio ☐ Billboard ☐ Newspaper ☐ WDH staff ☐ Other _____

Race (select all that apply): ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Don't know ☐ Decline to answer

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

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Sex at birth: ☐ Female ☐ Male **Gender identity:** ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Genderqueer, neither male nor female ☐ Other

Sexual orientation: ☐ Straight/heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Something else ☐ Don't know

SEXUAL HEALTH AND HISTORY

Do you have sex with (select all that apply): ☐ Females ☐ Males ☐ Other, please list:_____

How many sex partners have you had in the last 3 months? _____
What type of sex are you having? (select all that apply)
☐ Oral ☐ Giving partner ☐ Receiving partner
☐ Vaginal
☐ Anal ☐ Receptive partner ☐ Insertive partner

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 ☐ No ☐ Unknown
If yes, specify disease and date:_____
Contact type: ☐ Household ☐ Sexual ☐ Needle-sharing ☐ Blood exposure
Have you had a positive STD, HIV or viral hepatitis test in the past 12 months? ☐ Yes ☐ No
If yes, specify disease and date:_____

Females:
Are you pregnant? ☐ Yes, due date: _____ ☐ Possibly ☐ No ☐ Unknown

Date of last pelvic exam/pap test: _____☐ Unknown

Condom use with new partner: ☐ Always ☐ Sometimes ☐ Never

Condom use with main partner: ☐ Always ☐ Sometimes ☐ Never

Condom use with other partners: ☐ Always ☐ Sometimes ☐ Never

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

Sex with:
- ☐ Anonymous partners
- ☐ Partners met on apps or the internet
- ☐ More than one partner at a time

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

Sex in exchange for:
- ☐ Drugs
- ☐ Money
- ☐ Food
- ☐ Shelter
- ☐ Other, please list:_____

Homelessness:
- ☐ History of homelessness
- ☐ Currently homeless
- ☐ Both

Incarceration:
- ☐ History of incarceration
- ☐ Currently incarcerated
- ☐ Both

Illicit drug use:
- ☐ History of drug use
- ☐ Currently using drugs
- ☐ Both

Injection drug use, even one time:
- ☐ Methamphetamine
- ☐ Opioid (heroin, fentanyl, oxycodone, etc.)
- ☐ Other, please list:_____
_

Intranasal drug use, even one time:
- ☐ Cocaine
- ☐ Methamphetamine
- ☐ Opioid (heroin, fentanyl, oxycodone, etc.)
- ☐ Other, please list:_____

Other drug use, even one time:
- ☐ Marijuana (weed)
- ☐ Methamphetamine (smoking)
- ☐ Stimulants (Cocaine, Adderall, Ritalin, etc.)
- ☐ Party drugs (Ecstasy, poppers, etc.)
- ☐ Other, please list:_____

Tattoos or piercings:
- ☐ Unprofessional tattoos
- ☐ Unprofessional piercings
- ☐ Both

History of:
- ☐ Prior STDs or viral hepatitis
- ☐ HIV infection
- ☐ Consistently abnormal liver tests
- ☐ Immunosuppressive therapy
- ☐ Dialysis
- ☐ Working in a healthcare setting
- ☐ Blood exposure (under skin or mucous membranes)
- ☐ Blood transfusion, blood components, or organ transplant (prior to 1992)
- ☐ Recipient of clotting factor or blood concentrations (prior to 1987)

Baby Boomer:
- ☐ Born between 1945-1965

Born outside U.S.:

Client:	**Parent:**
☐ Africa	☐ Africa
☐ Asia	☐ Asia
☐ South America	☐South America

Mother – history of:
☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ STDs

Symptoms (select all that apply):
- ☐ Abdominal or pelvic pain
- ☐ Abnormal bleeding
- ☐ Abnormal penile or vaginal discharge
- ☐ Clay-colored stools
- ☐ Fever
- ☐ Frequent urination
- ☐ Night sweats
- ☐ Pain or bleeding with sex
- ☐ Pain or burning with urination
- ☐ Penile, vaginal, or anal itching
- ☐ Penile, vaginal, anal, or oral lesions, sores, or warts
- ☐ Rash, generalized or on your hands/feet
  List:_____
- ☐ Yellowing of the skin (jaundice)
- ☐ Other, please list:_____

For Staff Use Only

Visit Notes:

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

Areas to address with client	**Check or comments**
Confidentiality of records discussed (HIPAA)	
Informed Consent (as needed)	
Disease transmission and education	
Educate or refer to HIV Pre-Exposure Prophylaxis (PrEP), if indicated	
Identify personal risk behaviors and circumstances	
Offer condoms/dental dams/lube	
Expedited Partner Therapy (if available)	
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
	Site: Urine Vaginal Pharyngeal Rectal	
	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:_____

Positive Test Results	
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

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: _____