COMMUNICABLE DISEASE RISK ASSESSMENT

Today's Date: _____ Name of Clinic:_____

Client: Please complete pages 1 – 3

First Name: _____ **Last Name**:_____ **DOB:** _____ **Age:** __

Physical Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Other Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Phone: _____ **Email:** _____

Contact Restrictions: _____

Most severe housing status in the last 12 months: ☐ Homeless ☐ Unstably housed/at risk of losing housing ☐ Stably housed ☐ Don't know

Insurance: ☐ No Insurance ☐ Medicaid ☐ Private Insurance:_____ ☐ Medicare

Allergies:

Race (select all that apply): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other_____ ☐ Unknown

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

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

Gender at Birth: ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Transgender M to F ☐ Transgender F to M ☐ Genderqueer/Non-Binary ☐ Two-Spirit

Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Asexual ☐ Pansexual ☐ Queer ☐ Other: _____

Have you ever had three site testing? ☐ No ☐ Yes; Date: _____ ☐ What's that? ☐ I don't know

Number of sex partners in: Last 3 months?: _____ Your lifetime?: _____ Since last tested?: _____

Where do you meet your sex partner(s): ☐ Community_____

☐ Bar(s): _____ ☐ Bath House(s): _____

☐ Category 1: Facebook/Instagram/Snapchat/Twitter ☐ Category 3: Tinder/Grindr/Scruff /AFF

☐ Category 2: Match/eHarmony/Farmer's Only/Zoosk/Plenty of Fish/Hinge/Bumble ☐ Category 4: Other

Have you ever had an HIV test?: ☐ No ☐ Yes; Result:_____ Date:_____ Location:_____

Current HIV status: ☐ Positive ☐ Negative ☐ Unknown ☐ Decline to answer

Have you been vaccinated for: Hepatitis B? ☐ Yes ☐ No Hepatitis A? ☐ Yes ☐ No HPV? ☐ Yes ☐ No

Have you had a positive STD, HIV or viral hepatitis test in the past 12 months? ☐ Yes ☐ No

If yes, specify disease and date:

If you are female or you have female partner(s) are you using any form of birth control? ☐ No ☐ Yes: _____

Are you pregnant? ☐ Possibly ☐ Unknown ☐ No ☐ Yes, due date: _____ **Is your partner(s) pregnant?** ☐ Yes ☐ No

Are you currently trying to become pregnant or get someone pregnant? ☐ Yes ☐ No

First day of last period (if applicable) _____ **Date of last pelvic exam/pap**: _____ ☐ Unknown

Are you breastfeeding? ☐ No ☐ Yes **Is your partner(s) breastfeeding?** ☐ No ☐ Yes

Travel History:

Symptoms (select all that apply): Onset of symptoms:_____ Duration of symptoms:_____

☐ 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
☐ Rash, generalized or on your hands/feet ☐ Penile, vaginal, or anal itching ☐ Penile, vaginal, anal, or oral lesions, sores, warts
☐ Yellowing of the skin/eyes ☐ Testicular itching ☐ Pain – perineum
☐ Other, please list:_____

HealthCare Worker:

Working in a healthcare setting: ☐ Prior ☐ Present ☐ Screening for employment

History of (select all that apply):

☐ Blood transfusion, blood components, or organ transplant ☐ Blood exposure (under skin or mucous membranes)
☐ Recent pregnancy ☐ Current pregnancy ☐ Abnormal liver tests ☐ Positive hepatitis test
☐ Positive HIV test ☐ Prior STD ☐ Active TB ☐ Latent TB

Contact to: ☐ Hepatitis B+ ☐ Hepatitis C+ ☐ STD+ ☐ HIV+ ☐ Active TB ☐ Latent TB
Contact type: ☐ Household ☐ Needle share ☐ Sexual ☐ Blood exposure
If yes, specify disease and date:_____

Birth mother with history of (select all that apply):

☐ HIV+ ☐ Hepatitis B+ ☐ Hepatitis C+ ☐ STD+

Sexual History (select all that apply):

☐ Recent exposure to an STD ☐ New partner in last 3 months ☐ Polyamorous ☐ Kink/BDSM
☐ Survivor of sexual assault/abuse, past ☐ Survivor of sexual assault/abuse, current

Condom use with:

Main partner(s): ☐ Always ☐ Sometimes ☐ Never
Other partner(s): ☐ Always ☐ Sometimes ☐ Never
New partner(s): ☐ Always ☐ Sometimes ☐ Never
Previous partner(s): ☐ Always ☐ Sometimes ☐ Never

What type/s of sexual contact have you had in your lifetime? (Select all that apply):

With a male partner(s): Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive
With a female partner(s): Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive

Sex with (select all that apply):

☐ Anonymous partner(s) ☐ Partner(s) met on apps or the internet ☐ Pick-up(s) at bar ☐ Pick-up(s) at bath house
☐ STD+ partner(s) ☐ Hepatitis+ partner(s) ☐ HIV+ partner(s) ☐ IDU partner(s)
☐ MSM partner(s) ☐ Bisexual partner(s) ☐ Multiple partners
☐ Sex worker(s) ☐ Group sex

Sex while (select all that apply):

☐ Intoxicated ☐ High ☐ In public or semi-public place

Sex in exchange for (select all that apply):

☐ Drugs ☐ Money ☐ Food ☐ Shelter ☐ Other, please list: _____

Alcohol use:

Females:

How often do you drink 4 or more drinks in 2 hours? ☐ Never ☐ 1-2 times/month ☐ 3-4 times/month ☐5+ times/month

How often do you drink 3 or more drinks in one day (24 hours)? ☐ Never ☐ 1-2 times/month ☐ 3-4 times/month ☐5+ times/month

Males:

How often do you drink 5 or more drinks in 2 hours? ☐ Never ☐ 1-2 times/month ☐ 3-4 times/month ☐5+ times/month

How often do you drink 4 or more drinks in one day (24 hours)? ☐ Never ☐ 1-2 times/month ☐ 3-4 times/month ☐5+ times/month

Drug use: ☐ History of drug use ☐ Current drug use

	Method of use:					
Recreational drug(s) used:	Injection	Snorting, Snuffing (Intranasal)	Smoking	Inhaling	Ingesting (eat, drink)	Booty Bump (rectal, anal)
Cocaine						
Crack						
Opioids (heroin, fentanyl, oxycodone, etc.)						
Party drugs (ecstasy, poppers, molly, etc.)						
Erectile dysfunction medication						
Methamphetamine						
Marijuana						
Hallucinogens (LSD, psilocybin, DMT, PCP, ketamine)						
GHB						
OTC abuse (DXM, loperamide)						
Depressants (barbiturates, benzodiazepines, Ambien)						
Stimulants (Adderall, Concerta)						
Other:						

Shared works ☐ Yes ☐ No **Needle pooling** ☐ Yes ☐ No

Date of last drug use:_____

Number of partners who are/were both needle and sex partners: _____

Number of needle partners who are/were needle partners only: _____

Have you taken prescribed medication more often than prescribed? ☐ Yes ☐ No

Unprofessional/homemade tattoo(s): ☐ Yes ☐ No If yes, dates:_____

Unprofessional piercing(s): ☐ Yes ☐ No If yes dates:_____

Housing Risks:

Homelessness: ☐ History of homelessness ☐ Currently homeless

Incarceration: ☐ History of incarceration ☐ Currently incarcerated

Born outside U.S.:

Client: ☐ Africa ☐ Asia ☐ South America

Parent: ☐ Africa ☐ Asia ☐ South America

Baby Boomer: ☐ Born between 1945-1965

Would you like information regarding safe sex practices and/or prevention related to any kinks/fetishes? ☐ Yes ☐ No

For Staff Use Only

Completed	Areas to address with client	Comments
	Confidentiality of records discussed (HIPAA)	
	Informed Consent (as needed)	
	Transmission education	
	Identify personal risk behaviors and circumstances	
	Offer condoms/dental dams/lube	
	PrEP/PEP education: ☐ Educated ☐ Referred ☐ Taking ☐ Heard of ☐ Used in the last 12 months	

Risk Reduction Plan

☐ Increase condom use ☐ Dental dams ☐ Gloves ☐ Frequent testing ☐ Fewer partners

☐ Safe drug use/injection practice ☐ Only have the types of sexual contact for which willing to use a barrier method

_____

_____

_____

Referrals

Colorado Health Network: ☐ PrEP Navigation ☐ Hepatitis C Treatment

☐ Immunizations ☐ TB Testing ☐ Family Planning:_____

☐ Primary Care Provider:_____

☐ Other:_____

PRISM entry is required with 48 hours of result for all positive results and all CDU supplied rapid HIV tests.

Testing

Date tested	Test	Result (Circle One)	PRISM date entered
	Urine/Vaginal: Chlamydia	Positive/ Negative	
	Urine/Vaginal: Gonorrhea	Positive/ Negative	
	Pharyngeal: Chlamydia	Positive/ Negative	
	Pharyngeal: Gonorrhea	Positive/ Negative	
	Rectal: Chlamydia	Positive/ Negative	
	Rectal: Gonorrhea	Positive/ Negative	
	HIV rapid	Reactive/ Non-reactive	
	HIV confirmatory	Positive/ Negative	
	Syphilis RPR/Titer Titer _____:_____	Positive/ Negative	
	Syphilis Confirmatory: FTA	Positive/ Negative	
	Syphilis Confirmatory: TPPA	Positive/ Negative	
	Hepatitis B Surface Antigen (HBsAg)	Positive/ Negative	
	Hepatitis B Core Antibody- Total (HBcAb-Tot)	Reactive/ Non-reactive	
	Hepatitis B Surface Antibody (Anti-HBs) (vaccine)	Reactive/ Non-reactive	
	Hepatitis C Antibody	Reactive/ Non-reactive	
	Hepatitis C RNA	Detected/ Not Detected	

Visit Notes: _____

_____

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_____

Staff Signature: _____ **Date:** _____

Results Visit					
Client received results: Date**:**		☐ In person	☐ By phone	☐ Certified Letter	
☐ Unable to locate patient, provide justification:					
☐ Review risk reduction plan					
Need for follow up testing	☐ Recheck HIV in 6 months		☐ Recheck HCV in 6 months		
	☐ STD testing after each partner		☐ STD testing every 1-3 months		
	☐ +Pharyngeal GC, retest 7-14 days after treatment		☐ All +GC, retest in 3 months		
Follow up appointment if needed					
Updates on referrals					
Immunizations dates, if initiated:	Hep A:	Hep B:	HPV:	Td/Tdap:	Other:

Treatment (if positive):

☐ Medication instructions provided ☐ Disease information sheet provided

***Substitute Azithromycin 1gm single dose for Doxycycline in pregnant patients.**

Chlamydia Treatment			
Date	**Time**	**Administered by**	**Medication**
			PREFERRED TREATMENT: Doxycycline 100mg bid x 7d
			Doxycycline allergy: Azithromycin 1gm, PO x 1 dose

Gonorrhea Treatment			
Date	**Time**	**Administered by**	**Medication**
			PREFERRED TREATMENT for patient less than 300lbs with CT excluded: Ceftriaxone 500mg IM x 1 dose
			Patient 300lbs or greater with CT Excluded: Ceftriaxone 1gm IM
			Ceftriaxone allergy: Gentamycin 240 IM **PLUS** Azith 2gm po
			+GC when CT is **NOT** excluded for patient less than 300lbs: 500mg Ceftriaxone IM **PLUS** 100mg *Doxycycline po bid x 7 days
			+GC when CT is NOT excluded for patient 300lbs or greater: 1g Ceftriaxone IM **PLUS** 100mg *Doxycycline po bid x 7 days

Syphilis Treatment as instructed by CDU staff			
Date	**Time**	**Administered by**	**Medication**
			Primary, Secondary, and Early Latent: Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM
			Latent >1 year: **DOSE 1** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals
			Latent >1 year: **DOSE 2** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals
			Latent >1 year: **DOSE 3** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals

HIV, Hepatitis B, Hepatitis C

Referral made for: ☐ HIV Care & Case Management ☐ Hepatitis B ☐ Colorado Health Network for Hepatitis C treatment

Partner Notification/Services

Name: _____ DOB: _____
Address: _____
Email: _____ Phone number: _____
Date of last exposure: _____ Partner notified: ☐ Yes ☐ No Date: _____
Partner treated: ☐ Yes, date and treatment provided: _____ ☐ No, provide justification: _____
EPT provided: ☐ Yes, date and treatment provided: _____ ☐ No, provide justification: _____
Comments: _____

Staff Signature: _____ **Date:** _____

Partner Notification/Services - continued

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________

Name: ______________________________ DOB: ______________
Address: ______________________________
Email: ______________________________ Phone number: ______________
Date of last exposure: ______________ Partner notified: ☐ Yes ☐ No Date: ______________
Partner treated: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
EPT provided: ☐ Yes, date and treatment provided: ______________ ☐ No, provide justification: ______________
Comments: ______________________________