COMMUNICABLE DISEASE RISK ASSESSMENT

Client: Please complete pages 1 – 3

Demographic Information

First and Last Name: _____ **DOB:** _____ **Pronouns:** _____
Preferred Name: _____ **Other Name(s) Tested Under:** _____
Current Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Other Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Email:** _____
Preferred Contact Method: _____
Insurance: ☐ Uninsured/no insurance ☐ Medicaid ☐ Medicare ☐ Private Insurance: _____

Race (select all that apply): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Not Listed/Other: _____
Ethnicity: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Unknown ☐ Decline to answer
Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex
Gender Identity (select all that apply): ☐ Woman ☐ Man ☐ Transgender ☐ Genderqueer ☐ Non-Binary ☐ Two-Spirit ☐ Not listed, please specify: _____
Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Asexual ☐ Pansexual ☐ Queer ☐ Not listed, please specify: _____

Health History & Prior Testing

Allergies: _____
Have you ever been screened for STIs? ☐ No ☐ Yes; Date: _____ ☐ What's that? ☐ I don't know
Have you ever had extragenital STI testing? ☐ No ☐ Yes; Date: _____ ☐ What's that? ☐ I don't know
Have you ever had an HIV test? ☐ No ☐ Yes; Result: _____ Date: _____ Location: _____
Have you ever had a positive chlamydia, gonorrhea, hepatitis B, or hepatitis C test? ☐ Yes ☐ No
If yes, specify infection and date of positive test: _____ **Were you treated?** ☐ Y ☐ N ☐ I don't know
Have you ever been diagnosed with syphilis? ☐ Yes ☐ No
If yes, date of positive test: _____ **Were you treated?** ☐ Y ☐ N ☐ I don't know
Are you currently taking any supplements containing biotin (commonly found in multivitamins, hair, skin, & nail supplements, prenatal vitamins, etc.)? ☐ Yes ☐ No ☐ I don't know
Have you been vaccinated for: Hepatitis A? ☐ Y ☐ N Hepatitis B? ☐ Y ☐ N HPV? ☐ Y ☐ N Mpox? ☐ Y ☐ N ☐ I don't know my vaccination history

Reproductive Health

Are you and/or your partner(s) using any form of pregnancy prevention? ☐ No ☐ Yes (specify): _____
Are you pregnant? ☐ Possibly ☐ I don't know ☐ No ☐ Yes, due date: _____
Is your partner(s) pregnant? ☐ Yes ☐ No ☐ Unknown
Are you and/or your partner(s) currently trying to become pregnant? ☐ Yes ☐ No
First day of last period (if applicable): _____ **Date of last pelvic exam/pap (if applicable):** _____
Are you breastfeeding? ☐ Yes ☐ No **Is your partner(s) breastfeeding?** ☐ Yes ☐ No

Travel and Occupation History

Travel history in the last six months: _____
Have you worked in a healthcare setting? ☐ Yes, current ☐ Yes, prior ☐ No

Symptoms (select all that apply):

☐ Abdominal or pelvic pain ☐ Abnormal bleeding ☐ Abnormal penile or vaginal discharge
☐ Clay-colored stools ☐ Fever ☐ Rash, generalized or on your hands/feet
☐ Night sweats ☐ Pain or bleeding with sex ☐ Pain or burning with urination
☐ Testicular itching ☐ Frequent urination ☐ Penile, vaginal, anal, or oral lesions, sores, warts
☐ Yellowing of the skin/eyes ☐ Pain – perineum ☐ Penile, vaginal, or anal itching
☐ Not listed, please specify: _____

If Applicable: Onset of symptoms: _____ Duration of symptoms: _____

History of (select all that apply):

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

Are you a survivor of sexual assault/abuse? ☐ Yes ☐ No ☐ I don't know
Do you feel safe in your current relationship(s)? ☐ Yes ☐ No ☐ I don't know

Have you had contact with or exposure to an STI, HIV, hepatitis B, or hepatitis C? ☐ Yes ☐ No
If yes, specify infection and date of exposure: _____
If yes, contact type: ☐ Household ☐ Needle share ☐ Sexual ☐ Blood exposure

If known, parent with a history of (select all that apply): ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ STI

Sexual history (select all that apply):

☐ New partner ☐ Resumed sexual contact with a previous partner ☐ Polyamorous ☐ Kink/BDSM
☐ Sex work (stripping, escorting, prostitution, Only Fans, pornography)

Number of sex partners in the: Last three (3) months? _____ Last 12 months? _____

Where do you meet sexual contacts (select all that apply): ☐ Community/Friends: _____
☐ Bar(s): _____ ☐ Sex club(s): _____
☐ Gambling Establishment(s): _____ ☐ Social media/Snapchat: _____
☐ Dating/Hook up app(s): _____ ☐ Not listed: _____

How often do you use condoms during (select all that apply):

Vaginal sex: ☐ Never ☐ Less than half the time ☐ Half of the time ☐ More than half the time ☐ Always
Anal sex: ☐ Never ☐ Less than half the time ☐ Half of the time ☐ More than half the time ☐ Always
Oral sex: ☐ Never ☐ Less than half the time ☐ Half of the time ☐ More than half the time ☐ Always

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

With partners with male anatomy: Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive
With partners with female anatomy: Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive
Do you ever share sex toy(s)? ☐ Yes ☐ No

Sexual contact with (select all that apply):

☐ Anonymous partner(s) ☐ Partner(s) who have multiple other partners ☐ Male partner who has sex with men
☐ Multiple partners ☐ Partner(s) who use injection drugs ☐ Partner living with HIV, regardless of viral load
☐ Sex worker(s) ☐ More than one partner at the same time (e.g., group sex, threesome)

Sexual contact while (select all that apply): ☐ Drunk/Intoxicated ☐ High ☐ In public or semi-public place

Have you had sex (given or received) in exchange for (select all that apply): ☐ Drugs ☐ Money ☐ Food ☐ Shelter
☐ Not listed, please specify: _____

Alcohol use:

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

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

Drug use (select all that apply): ☐ Never ☐ History of drug use ☐ Current drug use **Date of last drug use:** _____

	Method of use:					
Substance(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)						
Not listed, please specify:						

Have you taken medication not prescribed to you or more often than prescribed? ☐ Yes ☐ No

Have you ever shared needles/rigs (needle pooling)? ☐ Yes ☐ No

Have you ever shared works (cotton, spoons, pipes, straws, etc.)? ☐ Yes ☐ No

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

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

Tattoo(s) and piercing(s):

Have you ever gotten unprofessional/homemade tattoo(s): ☐ Yes ☐ No If yes, date(s): _____

Have you ever gotten unprofessional/homemade piercing(s): ☐ Yes ☐ No If yes, date(s): _____

Housing & Incarceration:

In the last 12 months, have you been (select all that apply): ☐ Stably housed ☐ Unhoused/homeless ☐ Unstably housed/at risk of losing housing ☐ Don't know

Are you currently incarcerated or in jail? ☐ Yes ☐ No

Have you ever been: ☐ Unhoused (homeless) ☐ Incarcerated (in jail)

Country of Birth:

What is your country of birth? _____ **What is your parent(s) countries of birth:** _____

Have you ever heard of PrEP? ☐ No ☐ Yes, currently taking ☐ Yes, taken in last 12 months ☐ Yes, not currently taking ☐ I want more information

Would you like information regarding condom fit? ☐ Yes ☐ No

Would you like information regarding safe sex practices? ☐ Yes ☐ No

Would you like safety and/or prevention information related to any kinks/fetishes? ☐ Yes ☐ No

Would you like information regarding at-home STI, HIV, and HCV testing? ☐ Yes ☐ No

For Staff Use Only		
Completed	**Areas to address with client**	**Comments**
	Confidentiality of records discussed (HIPAA)	
	Informed Consent (as needed)	
	Current medications (list)	
	Transmission education	
	Identify personal risk behaviors and circumstances	
	Offer condoms/dental dams/lube	
	KnoWyo.org and Other KnoWyo Services	
	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 ☐ Fentanyl Test Strips
☐ Safer drug use/injection practice(s) ☐ Only have the types of sexual contact for which willing to use a barrier method
☐ If applicable, proper sex toy cleaning practices **Notes:** _____
_____

Referrals

Colorado Health Network: ☐ PEP Navigation ☐ PrEP Navigation ☐ Hepatitis C Treatment Navigation
☐ HIV Care & Case Management ☐ HBV Care ☐ Immunizations ☐ TB Testing ☐ Family Planning
☐ Safety Planning ☐ Mental Health Resources ☐ Other: _____

****PRISM entry is required within seven (7) days of result for all positive tests and all CDU-supplied rapid HIV tests.** Additional fields and answer options have been added to this form to improve cultural competency that may not have corresponding PRISM fields. In this case, please include any additional details in the "Notes" section of the field record.**

Testing & PRISM Entry			
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 blood draw (unable to use rapid)	Reactive/ Non-reactive	
	HIV confirmatory	Reactive/ Non-reactive	
	Syphilis RPR/Titer Titer ____:_____	Reactive/ Non-reactive	
	Syphilis confirmatory	Reactive/ Non-reactive	
	Hepatitis B Surface Antigen (HBsAg)	Reactive/ Non-reactive	
	Hepatitis B Core Antibody- Total (anti-HBc)	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	

KnoWyo Voucher Created: ☐ No ☐ Yes, Code: _____ ☐ Redeemed

Testing Visit Notes: _____
_____
_____
_____
_____
_____

Staff Signature: _____ **Date:** _____

Results Visit						
Client received results: Date**:**	☐ In person	☐ By phone	☐ Certified Letter			
Unable to locate patient, justify:						
☐ Review risk reduction plan	☐ Medication instructions provided to patient					
Need for follow-up testing:	☐ Recheck HIV in 6 months			☐ Recheck HCV in 6 months		
	☐ +Pharyngeal GC, retest 7-14 days after treatment			☐ STI testing after each partner		
	☐ All +CT and/or +GC, retest in 3 months			☐ STI testing every 1-3 months		
Follow-up appointment date, if needed:	Immunization dates, if initiated: Hep A:	Hep B:	HPV:	Td/Tdap:	Mpox:	Other:

Treatment (if positive):			
Chlamydia Treatment			
Date	**Time**	**Administered By**	**Medication**
			PREFERRED TREATMENT: Doxycycline 100mg bid x 7d
			*Doxycycline allergy or pregnancy: Azithromycin 1gm, PO x 1 dose
Gonorrhea Treatment			
Date	**Time**	**Administered By**	**Medication**
			PREFERRED TREATMENT for patients less than 330lbs with CT excluded: Ceftriaxone 500mg IM x 1 dose
			Patient 330lbs or greater with CT Excluded: Ceftriaxone 1gm IM
			Ceftriaxone allergy: Gentamycin 240 IM **PLUS** Azith 2gm po
Syphilis Treatment *<u>as Instructed by CDU Staff</u>*			
Date	**Time**	**Administered By**	**Medication**
			Primary, Secondary, and Early Latent: Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM
			Latent >1 year: **<u>DOSE 1</u>** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals
			Latent >1 year: **<u>DOSE 2</u>** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals
			Latent >1 year: **<u>DOSE 3</u>** Benzathine penicillin G 2.4mu (two 1.2mu tubex) IM x 3 doses at weekly intervals

Treatment Visit Notes: _____

_____

_____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Partner Notification/Services – Print Additional Pages as Necessary

Name: ______________________________ DOB: ____________
Address: ______________________________ City: ____________ State: ________
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: ______________________________ City: ____________ State: ________
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: ______________________________ City: ____________ State: ________
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: ______________________________ City: ____________ State: ________
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: ______________________________ City: ____________ State: ________
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: ______________________________ City: ____________ State: ________
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: ______________________________