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| **Risk Assessment Interview**  **for TB/HIV/STDs** | | | | | | **Name** | |  | | | | | |  |
| **ID Number** | |  | | | | | |  |
| **Date** | |  | | | | | |  |
| 1. | | Have you ever tested positive, been diagnosed with, or treated for tuberculosis (TB)? | | | | | | | | | | ❑Yes | ❑No | |
| 2. | | Has anybody you know or have lived with been diagnosed with or tested positive for TB in the past year? | | | | | | | | | | ❑Yes | ❑No | |
| 3. | | a. | Within the last month, have you had any of the following symptoms lasting for more than 2 weeks? If yes, please check items below. | | | | | | | | |  | ❑No | |
|  | | | ❑ Fever | ❑ Drenching night sweats | | | | | | | ❑ Coughing up blood | | | |
|  | | | ❑ Losing weight | ❑ Shortness of breath | | | | | | | ❑ Lumps or swollen glands | | | |
|  | | | ❑ Diarrhea lasting more than one week | | | |  | | | | | | | |
|  | | b. | Are you now living with someone with any of the following? | | | | | | | | |  | ❑No | |
|  | | | ❑ Coughing up blood | | ❑ Drenching night sweats | | | | | | ❑ Active TB | | | |
| 4. | | Have you ever been told that you have a positive HIV test? (test for the AIDS virus) | | | | | | | | | | ❑Yes | ❑No | |
| 5. | | Do you have a history of IV drug usage? | | | | | | | | | | ❑Yes | ❑No | |
| 6. | | Have you used cocaine (I.E., powder, crack...etc.)? | | | | | | | | | | ❑Yes | ❑No | |
| 7. | | Have you ever engaged in unprotected vaginal, anal or oral sex with multiple partners and/or anonymous partners? | | | | | | | | | | ❑Yes | ❑No | |
| 8. | | Have any of your current or previous sex partners used IV drugs or been HIV positive? | | | | | | | | | | ❑Yes | ❑No | |
| 9. | | Have you ever been paid to have sex or to exchange sex for food, shelter, etc.? | | | | | | | | | | ❑Yes | ❑No | |
| 10. | | Have you ever been the victim of sexual assault? | | | | | | | | | | ❑Yes | ❑No | |
| 11. | | Have you ever used alcohol or drug before or during sex? | | | | | | | | | | ❑Yes | ❑No | |
| 12. | | Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease? | | | | | | | | | | ❑Yes | ❑No | |
| 13. | | Have you ever lived on the street or in a shelter? | | | | | | | | | | ❑Yes | ❑No | |
| 14. | | Have you ever been incarcerated or in jail? | | | | | | | | | | ❑Yes | ❑No | |
| 15. | | Have you had a blood transfusion prior to 1992? | | | | | | | | | | ❑Yes | ❑No | |
| 16. | | Were you born between the years 1945 and 1965? | | | | | | | | | | ❑Yes | ❑No | |
| Comments: | | | | | | | | | | | | | | |
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| Staff Signature/Credentials | | | | | | | | Date | | | | |

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| **Educational Activities & Risk Assessments**  **for TB/HIV/STDs** | | | | | | | **Name** | | | | | | | | |
| **ID Number** | | | | | | | | |
| **Educational Activities** | | | | | | | | | | | | **Date Completed** | **Total Time** | | |
| 1. | HIV/AIDS Information (minimum of 1 hour required for funded SABG HIV-EIS programs)  (including modes of transmission, universal precautions and other preventative measures, current treatments and how to access them) | | | | | | | | | | |  |  | | |
| 2. | Sexually Transmitted Diseases (STDs)  (including modes of transmission, precautions to take against contraction, progression of diseases, current treatment resources and how to access them) | | | | | | | | | | |  |  | | |
| 3. | Tuberculosis  (including modes of transmission, current treatment resources and how to access them) | | | | | | | | | | |  |  | | |
| 4. | Hepatitis  (including modes of transmission, precautions to take against contraction, current treatments and how to access them) | | | | | | | | | | |  |  | | |
| **HIV Risk Assessment, Testing, & Counseling** | | | | | | | | | | | | **Date Completed** | **Total Time** | | |
| 1. | Completion of Risk Assessment Interview | | | | | | | | | | |  |  | | |
| 2. | Provided HIV Pre-Test Counseling (minimum of 30 minutes) | | | | | | | | | | |  |  | | |
| 3. | Provided HIV Testing | | | | | | | | | | |  |  | | |
|  |  | | ❑Yes |  | | | | | | | |  |  | | |
|  |  | | ❑No | ❑ Opt-out form completed for refusal of testing on: | | | | | | | |  |  | | |
| 4. | Provided Post-Test Counseling if testing was conducted (minimum of 30 minutes; 60 minutes for a reactive HIV test) | | | | | | | | | | |  |  | | |
| **Tuberculosis Risk Assessment, Testing, & Referral** | | | | | | | | | | | | | **Date Completed** | | |
| 1. | Completion of Tuberculosis Risk Assessment | | | | | | | | | | | |  | | |
|  | | | Do results indicate further action? | | | | | ❑Yes | | | ❑No | |  | | |
| 2. | | Completion of Skin Test | | | | | | | | | | |  | | |
|  | | | Do results indicate further action? | | | | | ❑Yes | | | ❑No | |  | | |
| 3. | | Completion of X-ray | | | | | | | | | | |  | | |
|  | | | Do results indicate further action? | | | | | ❑Yes | | | ❑No | |  | | |
| 4. | | Referred for Tuberculosis Treatment | | | | | | | | | | |  | | |
| By signing, you acknowledge receipt of the educational information and all risk assessments listed above. | | | | | | | | | | | | | | | |
|  | | | | |  |  | | |  |  | | | |  |  | |
| **Individual Receiving Services** | | | | |  | **Date** | | |  | **Staff Signature/Credentials** | | | |  | **Date** | |