|  |  |  |  |
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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** |