

## HIV/HCV TEST FORM

North Dakota Department of Health  
Division of Sexually Transmitted and Bloodborne Diseases  
SFN 60087 (Rev. 07/2021)

### CTR Site Information

Site ID:		Session Date:	
Site Type:	<input type="checkbox"/> CTR <input type="checkbox"/> School <input type="checkbox"/> Shelter <input type="checkbox"/> Outreach <input type="checkbox"/> Corrections <input type="checkbox"/> Public Place <input type="checkbox"/> Substance Abuse Treatment Facility <input type="checkbox"/> Community Health Center <input type="checkbox"/> Health Department		

### Client's Demographics

First Name		Last Name		Birth Date		Country of Birth	
Street Address		City		County		State	
				Zip Code		Phone Number	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused				Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused <input type="checkbox"/> Not Specified			
Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Unspecified <input type="checkbox"/> Another Gender <input type="checkbox"/> Refused						Assigned Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insurance Status: <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Expansion <input type="checkbox"/> No Insurance <input type="checkbox"/> Other <input type="checkbox"/> Unknown							
Was Client Billed for HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No				Was Client Billed for Hepatitis C Test? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Previous HIV Testing

Has Client Been Previously Tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, Date Tested: __/__/__
If yes, Reported Test Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Preliminary Positive	

### Previous HCV Testing

Has Client Been Previously Tested for HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, Date Tested: __/__/__
If yes, Reported Test Results: <input type="checkbox"/> HCV Ab Positive <input type="checkbox"/> HCV Ab Negative <input type="checkbox"/> HCV Positive <input type="checkbox"/> HCV RNA Positive <input type="checkbox"/> HCV RNA Negative <input type="checkbox"/> Unknown	

### HIV & Hepatitis C Test Information

HIV Test Information		HIV Confirmatory Test		HCV Test Information		HCV Confirmatory Test	
Collection Date: __/__/__		Collection Date: __/__/__		Collection Date: __/__/__		Collection Date: __/__/__	
Worker:		If rapid reactive, did client provide a confirmatory sample?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Referred	Worker:		If rapid reactive, did client provide a confirmatory sample?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Referred
Test Technology:	<input type="checkbox"/> Conventional <input type="checkbox"/> Rapid			Test Technology:	<input type="checkbox"/> Conventional <input type="checkbox"/> Rapid		
Test Result:	<input type="checkbox"/> Preliminary Positive <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Invalid	Test Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> Negative	Test Result:	<input type="checkbox"/> Preliminary Positive <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Invalid	Test Result:	<input type="checkbox"/> RNA Positive <input type="checkbox"/> RNA Negative <input type="checkbox"/> Conf. Ab Pos. <input type="checkbox"/> Conf. Ab Neg.
Results Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, client obtained results from another agency		Results Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, client obtained results from another agency		Results Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, client obtained results from another agency		Results Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, client obtained results from another agency	
Date Provided: __/__/__		Date Provided: __/__/__		Date Provided: __/__/__		Date Provided: __/__/__	
Why were results not provided?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Other	Why were results not provided?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Other	Why were results not provided?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Other	Why were results not provided?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Could Not Locate <input type="checkbox"/> Other

**Check which infections the client was also tested for:** ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis

If not, why: ☐ Patient Refused – Unable to Pay ☐ Patient Refused – Other ☐ Not Recommended by Provider ☐ Other

**For Chlamydia/Gonorrhea, please indicate which specimen sources were collected:** ☐ Urine/Vaginal ☐ Rectal ☐ Pharyngeal

### Viral Hepatitis Vaccine

Was hepatitis A and/or B vaccine given? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of vaccine given: <input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> Twinrix
If no, why? <input type="checkbox"/> Not at risk for HCV <input type="checkbox"/> Client indicated up to date <input type="checkbox"/> Facility no offer vaccine <input type="checkbox"/> Refused Vaccine <input type="checkbox"/> Private Vaccine Admin. <input type="checkbox"/> Provider verified client up to date <input type="checkbox"/> Refer to Imm. Clinic <input type="checkbox"/> Outreach Event	

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### Sexual Health History

1. Has client <b>EVER</b> reported having sex with a <b>Male</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<b>In the past five years</b> , did client report having sex with a <b>Male</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
2. Has client <b>EVER</b> had sex with a <b>Female</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<b>In the past five years</b> , did client report having sex with a <b>Female</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
3. Has client <b>EVER</b> had sex with an individual identifying as <b>Transgender</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<b>In the past five years</b> , did client report having sex with a <b>Transgender</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
4. Did Client <b>EVER</b> Report Injection Drug Use?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<b>In the past 5 years</b> , did client report Injection Drug Use?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Has Client <b>Ever</b> Shared Equipment or Supplies While Injecting Drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know

### Current Sexual Health Behaviors – Last 12 Months or Since Last Sexual Encounter Unless Otherwise Specified

1. The client's current sex partners are (Check All That Apply):	<input type="checkbox"/> Males	<input type="checkbox"/> Females	<input type="checkbox"/> Transgender Individuals	<input type="checkbox"/> Client has never had sex
2. How many individuals did the client have sex with in the <b>past 60 days</b> ?	<input type="checkbox"/> 0	<input type="checkbox"/> 1 – 2	<input type="checkbox"/> 3 - 5	<input type="checkbox"/> >5
3. How often does the client use condoms/other protection?	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the Time	<input type="checkbox"/> Not that Often	<input type="checkbox"/> Never
	<input type="checkbox"/> Client has never had sex or has not had sex in the past 12 months			
4. What type of sex has the client had in the past 12 months or since the client's last CT/GC test? (Check All That Apply)				
<input type="checkbox"/> No sex in past 12 months	<input type="checkbox"/> Vaginal Sex	<input type="checkbox"/> Oral Sex - Unspecified	<input type="checkbox"/> Oral Sex – Perform	<input type="checkbox"/> Oral Sex - Receive
		<input type="checkbox"/> Anal Sex – Unspecified	<input type="checkbox"/> Anal Sex – Top	<input type="checkbox"/> Anal Sex - Bottom
5. Has the client used drugs in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
If Yes: Methods of Drug Use (Check All That Apply):	<input type="checkbox"/> Inject	<input type="checkbox"/> Smoke	<input type="checkbox"/> Snort	<input type="checkbox"/> Ingest
	<input type="checkbox"/> Unknown			
6. Has the client had anonymous sex partners? (ex. used dating apps or met at bar)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

### Additional HIV Risk Factors - – Last 12 Months, Check all that apply.

<input type="checkbox"/> Exchange sex for drugs/money	<input type="checkbox"/> Sex with Person Living with HIV	<input type="checkbox"/> Victim of human/sex trafficking
<input type="checkbox"/> Sex with someone diagnosed with a STD	<input type="checkbox"/> Sex with someone who exchanges sex for drugs/money	<input type="checkbox"/> Had sex with a person who injects drugs
<input type="checkbox"/> Previously diagnosed with a STD	<input type="checkbox"/> Victim of sexual assault	<input type="checkbox"/> Patient requested testing
<input type="checkbox"/> Sex under influence of drugs or alcohol	<input type="checkbox"/> From Endemic HIV Region	
<input type="checkbox"/> Sex with multiple partners		

### Additional HCV Risk Factors - – Last 12 Months, Check all that apply.

<input type="checkbox"/> Have HIV infection	<input type="checkbox"/> Mother had HCV infection	<input type="checkbox"/> Had sex with HCV infected individual
<input type="checkbox"/> Received blood clotting factors before 1987	<input type="checkbox"/> Family member HCV Positive	<input type="checkbox"/> Baby Boomer screening (born between 1945 & 1965)
<input type="checkbox"/> Received blood transfusion or organ transplant before 1992	<input type="checkbox"/> Receiving long-term hemodialysis	<input type="checkbox"/> Sex with a person who injects drugs
<input type="checkbox"/> Abnormal liver tests	<input type="checkbox"/> Received tattoos or body piercings in a non-sterile setting	<input type="checkbox"/> Patient requested testing

### PrEP Awareness, Referrals and Eligibility Screening

1. Has the client ever heard of HIV PrEP?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Has the client used PrEP anytime in the previous 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is the client currently taking HIV PrEP?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Was the client <u>screened</u> for PrEP eligibility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is the client <u>eligible</u> for a PrEP referral?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, CDC Criteria <input type="checkbox"/> Yes, Local Criteria
Was the client <u>referred</u> to a PrEP provider?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was <u>navigation</u> or linkage services provided to assist with linkage to a PrEP provider?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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### Essential Support Services – All Clients

1. Was the client <u>assessed</u> for <b>health benefits navigation and enrollment</b> needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> health benefits navigation and enrollment services?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to services for health benefits navigation and enrollment services?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Was the client <u>assessed</u> for <b>evidence-based risk reduction intervention</b> needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> evidence-based risk reduction intervention services?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to evidence-based risk reduction intervention services?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Was the client <u>assessed</u> for <b>behavioral health</b> service needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Was the client <u>identified</u> as needing behavioral health services?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to behavioral health services?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Was the client <u>assessed</u> for <b>social services</b> needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Was the client <u>identified</u> as needing social services?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the client was <u>provided</u> or <u>referred</u> to social services?	<input type="checkbox"/> No <input type="checkbox"/> Yes

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### Additional Questions - Persons Diagnosed with HIV

1. Did client receive individualized behavioral risk reduction counseling?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. By client's self-report, what was the most unstable housing status experienced in the previous 12 months:	<input type="checkbox"/> Literally Homeless	<input type="checkbox"/> Unstably housed
	<input type="checkbox"/> Stably housed	<input type="checkbox"/> Not Asked
	<input type="checkbox"/> Declined	<input type="checkbox"/> Unknown
3. Is the client pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<input type="checkbox"/> Not Asked	<input type="checkbox"/> Declined to Answer
	<input type="checkbox"/> Unknown	
Has the client received prenatal care during the pregnancy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<input type="checkbox"/> Not Asked	<input type="checkbox"/> Declined to Answer
	<input type="checkbox"/> Unknown	

### Essential Support Services – Persons Diagnosed with HIV

1. Was the client <u>screened</u> for the need of <b>navigation for linkage to HIV medical care</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> navigation services for linkage to HIV medical care?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to navigation services for linkage to HIV medical care?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Was the client <u>screened</u> for the need of <b>linkage services to HIV medical care</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client <u>identified</u> as needing linkage services to HIV medical care?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> for linkage services to HIV medical care?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Was the client <u>assessed</u> for <b>health benefits navigation and enrollment</b> needs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> health benefits navigation and enrollment services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to services for health benefits navigation and enrollment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Was the client <u>assessed</u> if they needed <b>medication adherence support services</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified to <u>need</u> medication adherence support services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to medication adherence support services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Was the client <u>assessed</u> for <b>evidence-based risk reduction intervention</b> needs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> evidence-based risk reduction intervention services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to evidence-based risk reduction intervention services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### Behavioral Health Services & Social Services – Persons Diagnosed with HIV

1. Was the client <u>assessed</u> for <b>behavioral health services</b> needs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> behavioral health services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to behavioral health services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Was the client <u>assessed</u> for <b>social services</b> needs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client identified as <u>needing</u> social services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the client <u>provided</u> or <u>referred</u> to social services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes