NORTH Dakota | Health & Human Services
Be Legendary.

HIV/HCV TEST FORM

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

CTR Site Information OFFICE USE ONLY

Site ID:	Session Date:
Site Type:	☐ CTR ☐ School ☐ Shelter ☐ Outreach ☐ Corrections ☐ Public Place ☐ Substance Abuse Treatment Facility ☐ Community Health Center ☐ Health Department

Client's Demographics

First Name	*Last Name*	*Birth Date*			*Country of Birth*
Street Address	*City*	*County*	*State*	*Zip Code*	*Phone Number*

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	*Race:* ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused ☐ Not Specified
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Transgender Unspecified ☐ Another Gender ☐ Refused	*Assigned Sex at Birth:* ☐ Male ☐ Female
Insurance Status: ☐ Private ☐ Medicare ☐ Medicaid ☐ Medicaid Expansion ☐ No Insurance ☐ Other ☐ Unknown	
Were you billed for the HIV test? ☐ Yes ☐ No	*Were you billed for the Hepatitis C test?* ☐ Yes ☐ No

Previous HIV Testing

Has Client Been Previously Tested for HIV? ☐ Yes ☐ No ☐ Unknown	*If yes, Date Tested:* ___/___/___
If yes, Reported Test Results: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown ☐ Refused ☐ Preliminary Positive	

Previous HCV Testing

Has Client Been Previously Tested for HCV? ☐ Yes ☐ No ☐ Unknown			*If yes, Date Tested:* ___/___/___
If yes, Reported Test Results:	☐ HCV Ab Positive ☐ HCV RNA Positive	☐ HCV Ab Negative ☐ HCV RNA Negative	☐ HCV Positive ☐ Unknown

HIV & Hepatitis C Test Information OFFICE USE ONLY

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?	☐ Yes ☐ Refused ☐ Could Not Locate ☐ Referred	Worker:		If rapid reactive, did client provide a confirmatory sample?	☐ Yes ☐ Refused ☐ Could Not Locate ☐ Referred
Test Technology:	☐ Conventional ☐ Rapid	Test Result:	☐ Positive ☐ Indeterminate ☐ Invalid ☐ Negative	Test Technology:	☐ Conventional ☐ Rapid	Test Result:	☐ RNA Positive ☐ RNA Negative ☐ Conf. Ab Pos. ☐ Conf. Ab Neg.
Test Result:	☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Invalid			Test Result:	☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Invalid		
Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency		Results Provided? ☐ Yes ☐ No ☐ Yes, client obtained results from another agency	
Date Provided: ___/___/___		Date Provided: ___/___/___		Date Provided: ___/___/___		Date Provided: ___/___/___	
Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ Other	Why were results not provided?	☐ Declined Notification ☐ Could Not Locate ☐ 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 OFFICE USE ONLY

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

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Sexual Health History

1. Has you EVER had sex with a Male?	☐ No	☐ Yes	☐ Don't Know
In the past five years, have you had sex with a Male?	☐ No	☐ Yes	
2. Has you EVER had sex with a Female?	☐ No	☐ Yes	☐ Don't Know
In the past five years, have you had sex with a Female?	☐ No	☐ Yes	
3. Has you EVER had sex with an individual identifying as Transgender?	☐ No	☐ Yes	☐ Don't Know
In the past five years, have you had sex with a Transgender person?	☐ No	☐ Yes	
4. Have you EVER injected drugs?	☐ No	☐ Yes	☐ Don't Know
In the past 5 years, have you injected drugs?	☐ No	☐ Yes	
Has you ever shared equipment or supplies while injecting drugs?	☐ No	☐ Yes	☐ Don't Know

Current Sexual Health Behaviors – Last 12 Months or Your Last Sexual Encounter (Unless Otherwise Specified)

1. My current sex partners are (Check All That Apply): ☐ Males ☐ Females ☐ Transgender Individuals ☐ I have never had sex
2. How many individuals have you had sex with in the **past 60 days**? ☐ 0 ☐ 1 – 2 ☐ 3 - 5 ☐ >5
3. How often do you use condoms/other protection? ☐Always ☐Most of the Time ☐Not that Often ☐Never ☐ I have not had sex in the last 12 months
4. What type of sex have you had in the past 12 months or since your last chlamydia/gonorrhea test? (Check All That Apply)

☐ I have not had sex in past 12 months	☐ Vaginal Sex	☐ Oral Sex - Unspecified ☐ Anal Sex – Unspecified	☐ Oral Sex – Perform ☐ Anal Sex – Top	☐ Oral Sex - Receive ☐ Anal Sex - Bottom

5. Have you used drugs in the past 12 months? ☐ Yes ☐ No ☐ Unknown

   If Yes: Methods of Drug Use (Check All That Apply): ☐ Inject ☐ Smoke ☐ Snort ☐ Ingest ☐ Unknown

6. Have you had anonymous sex partners? (ex. used dating apps or met at bar) ☐ Yes ☐ No ☐ Unknown

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

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

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

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

PrEP Awareness, Referrals and Eligibility Screening

1. Have you ever heard of HIV PrEP?		☐ No	☐ Yes
2. Have you used PrEP anytime in the previous 12 months?		☐ No	☐ Yes
Are you currently taking HIV PrEP?		☐ No	☐ Yes
OFFICE USE ONLY 3. Was the client screened for PrEP eligibility?	☐ No	☐ Yes	
Is the client eligible for a PrEP referral?	☐ No	☐ Yes, CDC Criteria	☐ Yes, Local Criteria
Was the client referred to a PrEP provider?	☐ No	☐ Yes	
Was navigation or linkage services provided to assist with linkage to a PrEP provider?	☐ No	☐ Yes	

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Essential Support Services – All Clients OFFICE USE ONLY

1. Was the client assessed for **health benefits navigation and enrollment** needs?	☐ No	☐ Yes
Was the client identified as needing health benefits navigation and enrollment services?	☐ No	☐ Yes
Was the client provided or referred to services for health benefits navigation and enrollment services?	☐ No	☐ Yes
2. Was the client assessed for **evidence-based risk reduction intervention** needs?	☐ No	☐ Yes
Was the client identified as needing evidence-based risk reduction intervention services?	☐ No	☐ Yes
Was the client provided or referred to evidence-based risk reduction intervention services?	☐ No	☐ Yes
3. Was the client assessed for **behavioral health** service needs?	☐ No	☐ Yes
Was the client identified as needing behavioral health services?	☐ No	☐ Yes
Was the client provided or referred to behavioral health services?	☐ No	☐ Yes
4. Was the client assessed for **social services** needs?	☐ No	☐ Yes
Was the client identified as needing social services?	☐ No	☐ Yes
Was the client was provided or referred to social services?	☐ No	☐ Yes

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Additional Questions - Persons Diagnosed with HIV OFFICE USE ONLY

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

Essential Support Services – Persons Diagnosed with HIV OFFICE USE ONLY

1. Was the client screened for the need of **navigation for linkage to HIV medical care**?	☐ No	☐ Yes
Was the client identified as needing navigation services for linkage to HIV medical care?	☐ No	☐ Yes
Was the client provided or referred to navigation services for linkage to HIV medical care?	☐ No	☐ Yes
2. Was the client screened for the need of **linkage services to HIV medical care**?	☐ No	☐ Yes
Was the client identified as needing linkage services to HIV medical care?	☐ No	☐ Yes
Was the client provided or referred for linkage services to HIV medical care?	☐ No	☐ Yes
3. Was the client assessed for **health benefits navigation and enrollment** needs?	☐ No	☐ Yes
Was the client identified as needing health benefits navigation and enrollment services?	☐ No	☐ Yes
Was the client provided or referred to services for health benefits navigation and enrollment?	☐ No	☐ Yes
4. Was the client assessed if they needed **medication adherence support services**?	☐ No	☐ Yes
Was the client identified to need medication adherence support services?	☐ No	☐ Yes
Was the client provided or referred to medication adherence support services?	☐ No	☐ Yes
5. Was the client assessed for **evidence-based risk reduction intervention** needs?	☐ No	☐ Yes
Was the client identified as needing evidence-based risk reduction intervention services?	☐ No	☐ Yes
Was the client provided or referred to evidence-based risk reduction intervention services?	☐ No	☐ Yes

Behavioral Health Services & Social Services – Persons Diagnosed with HIV OFFICE USE ONLY

1. Was the client assessed for **behavioral health services** needs?	☐ No	☐ Yes
Was the client identified as needing behavioral health services?	☐ No	☐ Yes
Was the client provided or referred to behavioral health services?	☐ No	☐ Yes
2. Was the client assessed for **social services** needs?	☐ No	☐ Yes
Was the client identified as needing social services?	☐ No	☐ Yes
Was the client provided or referred to social services?	☐ No	☐ Yes