

**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:	<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			
Were you billed for the HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were you billed for the 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 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?	<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 Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> Negative	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		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	Test Result: <input type="checkbox"/> Preliminary Positive <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Invalid		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: ___/___/___		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		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 OFFICE USE ONLY**

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"/> Private Vaccine Admin.	<input type="checkbox"/> Client indicated up to date <input type="checkbox"/> Provider verified client up to date
<input type="checkbox"/> Facility no offer vaccine <input type="checkbox"/> Refer to Imm. Clinic	<input type="checkbox"/> Refused Vaccine <input type="checkbox"/> Outreach Event

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## Sexual Health History

1. Has you <b>EVER</b> had sex with a <b>Male</b> ? <b>In the past five years</b> , have you had sex with a <b>Male</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
2. Has you <b>EVER</b> had sex with a <b>Female</b> ? <b>In the past five years</b> , have you had sex with a <b>Female</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
3. Has you <b>EVER</b> had sex with an individual identifying as <b>Transgender</b> ? <b>In the past five years</b> , have you had sex with a <b>Transgender person</b> ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
4. Have you <b>EVER</b> injected drugs? <b>In the past 5 years</b> , have you injected drugs? Has you ever 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 Your Last Sexual Encounter (Unless Otherwise Specified)

1. My current sex partners are (Check All That Apply): <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Transgender Individuals <input type="checkbox"/> I have never had sex
2. How many individuals have you had 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 do you 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"/> 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) <input type="checkbox"/> I have not had 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. Have you 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. Have you 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. Have you ever heard of HIV PrEP?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Have you used PrEP anytime in the previous 12 months? Are you currently taking HIV PrEP?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>OFFICE USE ONLY</b> 3. Was the client <u>screened</u> for PrEP eligibility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Is the client <u>eligible</u> for a PrEP referral?</i>	<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
<i>Was <u>navigation</u> or linkage services provided to assist with linkage to a PrEP provider?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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### Essential Support Services – All Clients **OFFICE USE ONLY**

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 OFFICE USE ONLY

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 OFFICE USE ONLY

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
<i>Was the client <u>provided</u> or <u>referred</u> to navigation services for linkage to HIV medical care?</i>	<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 <u>needing</u> linkage services to HIV medical care?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Was the client <u>provided</u> or <u>referred</u> for linkage services to HIV medical care?</i>	<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
<i>Was the client <u>provided</u> or <u>referred</u> to services for health benefits navigation and enrollment?</i>	<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
<i>Was the client <u>provided</u> or <u>referred</u> to medication adherence support services?</i>	<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
<i>Was the client <u>provided</u> or <u>referred</u> to evidence-based risk reduction intervention services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

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
<i>Was the client <u>provided</u> or <u>referred</u> to behavioral health services?</i>	<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
<i>Was the client <u>provided</u> or <u>referred</u> to social services?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes