

TESTING QUESTIONNAIRE

Test ID A# Sticker Here

Today's Date: / /				
Date of Birth: / /		State Where You Live	County Where You Live	Your Zip Code
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race (Check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not specified	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female (MTF) <input type="checkbox"/> Transgender Female to Male (FTM) <input type="checkbox"/> Transgender - Unspecified <input type="checkbox"/> Another Gender	
Have you ever been tested for HIV previously? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		If you have been tested for HIV before, what was the result? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Don't know		
To the best of your knowledge, in the past 5 years have you:				
Had vaginal or anal sex with a male? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a male without using a condom? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a male who injects drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a male who is HIV+? <input type="checkbox"/> Yes <input type="checkbox"/> No	Had vaginal or anal sex with a female? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a female without using a condom? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a female who injects drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a female who is HIV+? <input type="checkbox"/> Yes <input type="checkbox"/> No	Had vaginal or anal sex with a transgender person? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a transgender person without using a condom? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a transgender person who injects drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Had vaginal or anal sex with a transgender person who is HIV+? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To the best of your knowledge, in the past 5 years have you:				
Injected drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Shared injection drug use equipment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Check the box for yes: (Check all that apply)

- ☐ Have you ever heard of PrEP (Pre-Exposure Prophylaxis)?
- ☐ Are you currently taking daily PrEP medication?
- ☐ Have you used PrEP any time in the last 12 months?

TESTING QUESTIONNAIRE

For Testing Staff Only

HIV Test Election

☐ Anonymous ☐ Confidential ☐ Test Not Done

Worker Name (Enter in Worker ID Field): _____

Test Type:

(When entering into EvaluationWeb, select only the **final** test type. If an HIV lab-based test was performed via a blood draw, select lab-based test. If **only** a rapid test was performed via fingerstick, select rapid test in EvaluationWeb.)

☐ CLIA-waived Rapid Test(s)

☐ Laboratory-based Test

Sample Date: _____

Sample Date: _____

☐ Preliminary Positive

☐ HIV-1 Positive

☐ Negative

☐ HIV-1 Positive, possible acute

☐ Invalid

☐ HIV-2 Positive

☐ HIV Negative

☐ Inconclusive, further testing needed

Result provided to the client?

☐ No ☐ Yes ☐ Yes, client obtained the result from another agency

For HIV Negative Results Only:

Is the client at risk for HIV infection?

☒ Risk Not Assessed

Was the client screened for PrEP eligibility?

☐ No ☐ Yes

Is the client eligible for PrEP referral?

☐ No ☐ Yes, by CDC criteria

Was the client given a referral to a PrEP provider?

☐ No ☐ Yes

Was the client provided services to assist with linkage to a PrEP provider?

☐ No ☐ Yes

Co-Infections: (Check if applicable)

Was the client tested for Syphilis?

☐ No ☐ Yes ----->

Syphilis Test Result:

☐ Newly identified infection ☐ Not infected ☐ Not known

Was the client tested for Gonorrhea?

☐ No ☐ Yes ----->

Gonorrhea Test Result:

☐ Positive ☐ Negative ☐ Not known

Was the client tested for Chlamydia?

☐ No ☐ Yes ----->

Chlamydial Test Result:

☐ Positive ☐ Negative ☐ Not known

Was the client tested for Hepatitis C?

☐ No ☐ Yes ----->

Hepatitis C Test Result:

☐ Positive ☐ Negative ☐ Not known

Essential Health Benefits: (Check box for yes, check all that apply)

Screened for Need

Need Determined

Provided or Referred

Health benefits navigation and enrollment

☐
☐
☐

Evidence-based risk reduction intervention

☐
☐
☐

Behavioral health services

☐
☐
☐

Social services

☐
☐
☐

 (HIV+ Only) Navigation services for linkage to HIV care
(Referred to a Linkage to Care Specialist)

☐
☐
☐

 (HIV+ Only) Linkage services to HIV medical care
(Referred to a Provider)

☐
☐
☐

(HIV+ Only) Medication adherence support

☐
☐
☐