

Risk Assessment for Communicable Disease

Client Name: _____

Date: _____

Part I – HIV/AIDS, Hepatitis, STD

1. Have you engaged in unprotected sexual intercourse (oral, anal, or genital) with one or more partners whose HIV status is unknown? Yes No
2. Have you engaged in sexual activity with individuals who have been identified as HIV positive?
 Yes No
3. Have you shared needles or injecting “works” with other individuals? Yes No
4. Have you experienced other forms of blood contact where you have questions about your HIV status, i.e. blood transfusions, hemophilia treatments, etc.? Yes No
5. Have you been exposed to Hepatitis? Yes No
6. Have you been treated for Hepatitis? Yes No
7. Have you been exposed to a sexually transmitted disease? Yes No
8. Have you been treated for a sexually transmitted disease? Yes No

Part II – Tuberculosis

1. Have you been exposed to Tuberculosis? Yes No
2. Have you ever tested positive for Tuberculosis? Yes No
3. Have you received treatment for Tuberculosis? Yes No
4. Did you complete recommended treatment for Tuberculosis? Yes No
5. Are you a returning veteran from Afghanistan or have you been in close contact with someone who has been deployed to that country? Yes No

For Clinical Staff Only: *Written information on communicable disease to be provided to clients, regardless of answers on screen.*

High Risk for Communicable Disease: Yes No

Client is pregnant: Yes No

If yes, please complete the following:

1. Health Education, specific to Communicable Diseases:
 - Written materials provided
 - Scheduled for didactic
 - Information on local referrals
2. Referral for further services (testing) related to Communicable Diseases:
 - Primary Care Physician
 - Other (Health Department, Planned Parenthood, local resources)
 - Not applicable, client already receiving or has received, appropriate services

Clinician Signature

Date
