# HTS Contracted Testing

**Test Session ID:**

## Administrative Information

**Session Date*** **Site ID*** **Counselor ID***

**Client's program ID or Medical Record Number (MRN)**

## Client Identification

**Client's Name**

**First Name*** **Middle Initial** **Last Name***

**Date of Birth***

**Current Housing Status* (mark only one)**

- ○ Not Homeless/Has a permanent living
- ○ Homeless, living outdoors
- ○ Homeless, staying in a shelter or transitional housing
- ○ Homeless, sleeping in a car or temporary indoors
- ○ Homeless, but cannot or will not give more details
- ○ Unable/Unwilling to give any information as to housing status

**Client's Zip Code***
(use "99999" if unknown)

☐ Unable to obtain client's zip code

**Client's Full Address**

**House Number** **Street** **(St, Ave, Blv, Dr)** **Unit**

**City** **Zip Code**

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Address Cross Streets (if zip code not collected)

Phone Number (home)

Phone Number (cell)

## Client Information

**Gender Identity* (mark only one)**

- Male
- Female
- Transgender Female/Trans Woman
- Transgender Male/Trans Man
- Another gender
- Gender non-binary, gender non-conforming
- Prefer not to state

**Sex at Birth* (mark only one)**

- Male
- Female
- Non-binary or X
- Declined
- Other

**Sexual Orientation (mark only one)**

- Bisexual
- Gay or Lesbian
- Straight or Heterosexual
- Something else
- Not Sure
- Prefer not to state
- Don't understand

**Health Insurance Status**

- Insured
- Uninsured
- Don't Know

**Ethnicity* (mark only one)**

- Hispanic/Latinx
- Non-Hispanic/Non-Latinx
- Declined
- Don't know

**Race* (mark all that apply)**

- Afrian American/Black
- American Indian/Alaska Native
- Asian
- Native Hawiian/Pacific
- White
- Not Specified
- Declined

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## Client Behavior

**Has client been incarcerated within the past 12 months?**

○ Yes ○ No ○ Don't know

**Did the client have sexual contact in the last 12 months?**

○ Yes ○ No

**Type(s) of sexual contact (mark all that apply)**

○ Anal Insertive ○ Anal Receptive ○ Gave Oral ○ Got Oral

○ Vaginal

**Gender of client's sex partner(s) (mark all that apply)**

○ Male ○ Female ○ Transgender Female/Trans Woman

○ Transgender Male/Trans Man ○ Gender Non-Binary, Gender Non-Conforming

○ Another gender category or another identity ○ Declined

**In the past 12 months, has client had *Anal or Vaginal Sex*:**

Without a condom

○ Yes ○ No ○ Don't Know ○ Declined

With more than one partner

○ Yes ○ No ○ Don't Know ○ Declined

With a partner who had other concurrent sex partner(s)

○ Yes ○ No ○ Don't Know ○ Declined

With a person on PrEP

○ Yes ○ No ○ Don't Know ○ Declined

In exchange for money, drugs, shelters, etc.

○ Yes ○ No ○ Don't Know ○ Declined

While using alcohol

○ Yes ○ No ○ Don't Know ○ Declined

While using methamphetamines

○ Yes ○ No ○ Don't know ○ Declined

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With a partner who injects non-prescribed drugs or substances

○ Yes ○ No ○ Don't Know ○ Declined

With a partner who was incarcerated within the past 12 months

○ Yes ○ No ○ Don't Know ○ Declined

With an HIV positive person

○ Yes ○ No ○ Don't Know ○ Declined

If yes, was partner on antiretroviral therapy (ART) and virally suppressed

○ Yes ○ No ○ Don't Know ○ Declined

**In the past 12 months, has client:**

Had four or more alcoholic drinks in one day at least twice in one week

○ Yes ○ No ○ Declined

Injected a non-prescribed drug/substance (narcotics, hormones, etc.)

○ Yes ○ No ○ Declined

Shared any injection equipment

○ Yes ○ No ○ Declined

Used cocaine (including crack cocaine)

○ Yes ○ No ○ Declined

Used heroin

○ Yes ○ No ○ Declined

Used marijuana

○ Yes ○ No ○ Declined

Used methamphetamine

○ Yes ○ No ○ Declined

Used prescription opioids

○ Yes ○ No ○ Declined

Used poppers

○ Yes ○ No ○ Declined

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## Additional Background Information

**Was client exposed to HIV within the past 72 hours (3 days)?**

○ Yes ○ No ○ Don't Know ○ Declined

**Has client ever used PEP for HIV prevention?**

○ Yes ○ No ○ Don't Know ○ Declined

**Was client referred to PEP services?**

○ Yes ○ No

**Has client ever heard of PrEP, the medicine taken to reduce the risk for getting HIV?**

○ Yes ○ No

**Has client ever used PrEP?**

○ Yes ○ No

**Is client currently on PrEP ?**

○ Yes ○ No

**If client is not currently on PrEP, has client used PrEP in the past 12 months?**

○ Yes ○ No

## HIV Testing

**Was client tested for HIV in the past?**

○ Yes ○ No ○ Don't Know

**If client has tested for HIV in the past, what was the last HIV test result (self-reported)?**

○ Positive ○ Negative ○ Declined ○ Don't Know

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**HIV Test Results (mark result for each test done)**

| | |
|---|---|
| Rapid HIV Test Result (conducted on-site) | ○ Positive/Reactive ○ Negative |
| In-Home HIV Test Result | ○ Positive/Reactive ○ Negative ○ Unknown |
| HIV Ag/Ab Combo Assay Laboratory Test Result | ○ Positive/Reactive ○ Negative |

**Was client informed of the HIV test result? If HIV test was self-administered by the client, through a home-based test kit, leave blank.**

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

**Was STD tests performed?**

○ Yes

## STD Testing

| | | Result |
|---|---|---|
| Was client tested for chlamydia? | ○ Yes<br>○ No | ○ Positive/Reactive<br>○ Negative<br>○ Unknown |
| Was client tested for gonorrhea? | ○ Yes<br>○ No | ○ Positive/Reactive<br>○ Negative<br>○ Unknown |
| Was client tested for syphilis? | ○ Yes<br>○ No | ○ Positive/Reactive<br>○ Negative<br>○ Unknown |
| Was client tested for hepatitis C using a lab-based test? | ○ Yes<br>○ No | ○ Positive/Reactive<br>○ Negative<br>○ Unknown |

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| | | |
|---|---|---|
| Was client tested for hepatitis C using a rapid test? | ○ Yes<br>○ No | ○ Positive/Reactive<br>○ Negative<br>○ Unknown |

**If a rapid hepatitis C test was conducted, were referrals provided?**

○ Yes ○ No

## Prevention Services

**Was client provided risk reduction counseling?**

○ Yes ○ No

**Was client provided with condoms?**

○ Yes ○ No

**Is client interested in starting PrEP?**

○ Yes ○ No

**Was client referred to a PrEP provider (navigator or medical provider)?**

○ Yes ○ No ○ Declined

**Where was the client referred for PrEP? Write name of PrEP Provider (navigator or medical provider)**

**Was client provided with linkage services to a PrEP provider (navigator or medical provider)?**

○ Yes ○ No

**Who did you (the counselor) speak with? (provide name of PrEP staff)**

**PrEP Appointment Date (mm/dd/yyyy)**

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## Other Services

**Was client referred to any of the following services?**

| Evidence-based Risk Reduction | Health Benefits Navigation and Enrollment Services | Mental Health Services | Social Services | Substance Use Treatment Services | Syringe Services Program |
|---|---|---|---|---|---|
| ○ Yes ○ No | ○ Yes ○ No | ○ Yes ○ No | ○ Yes ○ No | ○ Yes ○ No | ○ Yes ○ No |

## Pregnancy Information

**Is client currently pregnant?**

○ Yes ○ No ○ Don't Know ○ Declined

**In prenatal care?**

○ Yes ○ No ○ Don't Know ○ Declined ○ Not Asked

**If pregnant, what is the due date?**

**If client is pregnant and not in prenatal care, was client provided a referral?**

○ Yes ○ No

## Notes

## Alternate Contact Information

**First Name** **Last Name** **Phone Number**

## HIV Testing & Treatment History

**Date of first positive HIV test** **Date of last HIV negative test**

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**Has client ever tested negative?**

- ○ Yes
- ○ No
- ○ Don't Know
- ○ Declined

**Has client seen an HIV medical care provider in the past 6 months?**

- ○ Yes
- ○ No
- ○ Don't Know
- ○ Declined

## HIV Laboratory Results

**Did client receive a confirmatory HIV laboratory test?**

○ Yes ○ No

**Was client informed of the confirmatory HIV laboratory test results?**

○ Yes ○ No

## HIV Treatment & Service Referrals

**Was client provided individualized behavioral risk-reduction counseling?***

○ Yes ○ No

**Was client linked to rapid ART services?**

○ Yes ○ No ○ Refused

**Was client referred to HIV medical care?***

○ Yes ○ No

**Where was the client referred? (write name of medical clinic)?**

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**Reason why a referral to medical care for HIV-positive client was not made**

- ○ Client already in care
- ○ Client declined care

**Was client provided with linkage services to HIV medical care?***

- ○ Yes
- ○ No

**Was client linked to HIV medical care?***

- ○ Yes
- ○ No
- ○ Don't Know

**Where was the client linked to HIV medical care? (write name of medical clinic)**

**Who did you (the counselor) speak with? (write name of medical staff)**

**First Medical Care Appointment Date (mm/dd/yyyy)**

**Did client attend first appointment? (mark only one)**

- ○ Yes, base on client's self report
- ○ Yes, base on confirmatin with medical care provider medical records review, surveillance, etc.
- ○ No
- ○ Don't Know

## Notes

## Partner Service

**Did you elicit partners from this client?**

- ○ Yes
- ○ No