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

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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