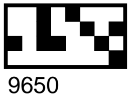


Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

Shade Circles Like This--> ●

Not Like This-->

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

SESSION AND REFERRAL INFORMATION

Session: *(choose only one)*

- O Session 1
- O Final Session
- O 60 Day Follow Up

Program ID:

Site ID:

Intervention Type: *(choose only one)*

- O Individual Level Intervention (IDI)
- O Comprehensive Risk Counseling Service (CRCS)

Date: *(mm/dd/yy)* __ __ / __ __ / __ __

Time of Encounter: :
- ○ AM
- ○ PM

Length of Contact: *(minutes)*

Complete this section for IDI and CRCS encounters at the FIRST SESSION ONLY:

How was client referred? *(choose only one)*

- O Agency***
- O Friend/Family
- O HC/PI
- O Self
- O Partner
- O Don't Know
- O Other, specify:

*****If client was referred from an agency, which program?**
(choose only one)

- O HCT
- O HC/PI
- O Partner Services
- O CRCS
- O HE/RR
- O Outreach Encounter
- O Intake
- O Don't Know
- O Other

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*

- O Tested at encounter
- O Referred for testing
- O Declined/refused testing
- O No testing referral

Place Test Lab Sticker #1 Below

Referrals: *(choose all that apply)*

- O No referrals provided

Risk/Harm Reduction

- O Comprehensive risk counseling (CRCS)
- O HIV education & prevention services
- O Follow-up HIV counseling
- O Prevention skill development
- O Prevention support group
- O Individual psychotherapy/counseling

Substance Use Services

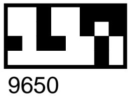
- O Alcohol/Drug Treatment
- O Harm reduction services
- O Syringe exchange program (SEP)

Positive Referrals

- O HIV medical care
- O HIV case management

Other Referrals

- O HCV medical services
- O Post exposure prophylaxis (PEP)
- O Hepatitis testing/vaccination
- O General medical services
- O Other referral, specify:
- O Social services
- O Reproductive services
- O STD testing & treatment
- O TB testing & treatment


9650

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COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

CLIENT BACKGROUND INFORMATION

First Name Initial: ☐ **Last Name Initial:** ☐

Date of Birth: *(mm/dd/yy)*
☐☐ / ☐☐ / ☐☐

Incarcerated? ○ Yes ○ No ○ Declined/Refused
(In last 12 months or since last session)

Residence Zip Code:
☐☐☐☐☐

What country was the client born in?
☐☐☐☐☐☐☐☐☐☐☐☐☐

Is client a sex worker? ○ Yes ○ No

Gender Identity: *(choose only one gender)*

- ○ Male
- ○ Female
- ○ Transgendered: M to F
- ○ Transgendered: F to M
- ○ Other, specify: ☐

Gender at Birth: *(choose only one)*

○ Male ○ Female

Pregnant? ○ Yes ○ No ○ Client doesn't know

If Yes, in Perinatal Care? ○ Yes ○ No

Homeless Status: *(choose only one)*

- ○ Not Homeless/Has a permanent living situation indoors
- ○ Homeless, living outdoors
- ○ Homeless, staying in a shelter or transitional housing where other services are provided
- ○ Homeless, sleeping in a car or temporary indoor situation without additional services
- ○ Homeless, but cannot or will not give more detail
- ○ Unable or unwilling to give any information as to homeless status

Race/Ethnicity: *(choose all that apply)*

- ○ Black / African-American
- ○ Asian
- ○ American Indian/ Alaska Native
- ○ White
- ○ Hispanic/ Latino(a)
- ○ Don't Know
- ○ Native Hawaiian/ Pacific Islander
- ○ Decline/Refused to Answer
- ○ Other race, specify: ☐

Sexual Orientation: *(choose only one)*

- ○ Heterosexual/straight
- ○ Bisexual
- ○ Gay or lesbian
- ○ Declined/Refused
- ○ Other, specify: ☐

Current Health Insurance Coverage: *(choose all that apply)*

- ○ No coverage
- ○ Medi-Cal (Medicaid)
- ○ Private
- ○ Indian Health Service
- ○ Military
- ○ Other, specify: ☐
- ○ Medicare

Partner Services (PS) discussed/offered to client?
(choose only one)

- ○ No, PS not discussed
- ○ Yes, client declined services
- ○ Yes, PS referred out
- ○ Yes, PS activities this session

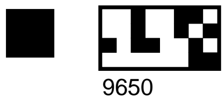
(If yes to activities this session, initial below and indicate activities in PS Activities section) to the right)

PS Initials/ID ☐☐☐☐ (if activities)

If PS activities took place this session, indicate activities below and fill in PS initials/ID in section on left.

PS Activities: *(choose all that apply)* # of Partners (1-999)

- ○ Skill building w/ client for self notification (indicate # of partners) ☐☐☐
- ○ Anonymous third party notification (indicate # of partners) ☐☐☐
- ○ Dual client/partner session (indicate # of partners) ☐☐☐



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SEXUAL BEHAVIOR HISTORY

Did client have vaginal or anal sex in the last 12 months or since the last session? ○ **Yes** ○ **No**

If yes, please complete questions below. If NO, SKIP to page 4.

If this is client's FIRST SESSION, complete the section labeled "In the Last 12 months".

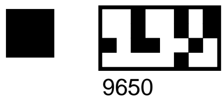
If this is client's FINAL SESSION or 60 DAY FOLLOW UP, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

	COMPLETE THIS COLUMN IF THIS IS YOUR FIRST SESSION			COMPLETE THIS COLUMN AT ALL OTHER SESSIONS			
	LAST 12 MONTHS			**SINCE THE LAST SESSION**			**ALWAYS COMPLETE**
SEX ACTIVITY	**All Partners in Last 12 Months**			**All Partners Since Last Session**			**Always used condoms during sex activity**
	Male	**Female**	**Transgender**	**Male**	**Female**	**Transgender**	
Oral Sex	○	○	○	○	○	○	
Vaginal Sex	○	○	○	○	○	○	○
Anal Sex	○	○	○	○	○	○	○
Exchanged sex for drugs/money/ something needed	○	○	○	○	○	○	○
Sex while intoxicated/ high on drugs	○	○	○	○	○	○	○
Sex with a partner who is an IDU	○	○	○	○	○	○	○
Sex with a partner who is HIV+	○	○	○	○	○	○	○
Sex with a partner whose HIV status is unknown	○	○	○	○	○	○	○
Sex with a partner who exchanges sex for drugs/money/etc.	○	○	○	○	○	○	○
Sex with anonymous partner	○	○	○	○	○	○	○
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	○		○	○		○	○

How many partners has the client had vaginal or anal sex with in past 30 days? (0-999)

Male	Female	Transgender
☐☐☐	☐☐☐	☐☐☐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Risk Assessment
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SUBSTANCE USE HISTORY

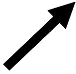
In the last 12 months OR since the last session, has client injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes O No

Has client EVER injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes O No

SUBSTANCES USED
(Last 12 months or Since the Last Session)

O No alcohol or drug use O Declined/Refused

If no drug use in last 12 mo. or since last session, skip the section to the right



Mark all substances used:	Injected:		Had sex while high or intoxicated:	
O Alcohol			O Yes	O No
O Methamphetamine	O Yes	O No	O Yes	O No
O Cocaine (Powder)	O Yes	O No	O Yes	O No
O Crack (Rock)	O Yes	O No	O Yes	O No
O Heroin (dope, junk, skag, smack, H)	O Yes	O No	O Yes	O No
O Other Drug, Specify:	O Yes	O No	O Yes	O No

HIV Test Information

Number of prior HIV tests:
(enter "0" if never tested before today)

O Declined/Refused to Answer

Date of last HIV test result received? *(mm/yy)* __ __ / __ __

If you have tested before, what was the last test result you received? *(Choose only one)*

O Negative

O Positive

O Preliminary positive (no confirmatory result received by client)

O Inconclusive, discordant, invalid

O Never received a result

O Declined/Refused to Answer

HIV Medical Care

If client states he/she is HIV+, complete the following questions.
If this is the FIRST session, answer the questions for the past 6 months. For all other intervention sessions or follow up, answer the following questions in terms of 'since last session:

How many times did you see a health care provider for your HIV? Please don't include times when you had an emergency room visit or a hospital admission, or only had a lab test done.

If first session, # in past 6 months.
All other sessions, # since last session.

Enter # from 0-199

O Declined/Don't Know

Date of last HIV medical care visit? *(mm/yy)* __ __ / __ __

If client tested positive today and was not referred this visit, why? (Choose only one)

O Client already in care

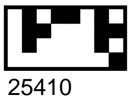
O Client declined care

STDs & HEPATITIS: Last 12 Months or Since the Last Session *(choose all that apply):*

O No STDs/Hepatitis	O Chlamydia	O Genital Herpes (HSV)
O Syphilis (syph, the pox, lues)	O Human Papilloma Virus (HPV)	O Hepatitis C (HCV)
O Gonorrhea (GC, clap, drip)	O Trichomoniasis (trich)	O Other STD, specify:
O Hepatitis A (HAV)	O Hepatitis B (HBV)	

Have you EVER been vaccinated for either of the following? *(choose all that apply):*

O Hepatitis A O Hepatitis B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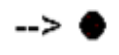
Cuestionario Auto-Administrado

Cuando escriba letras ó números, coloque un caractér en cada casilla. Escriba en letras mayúsculas solamente.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

UTILIZE UNA PLUMA DE TINTA NEGRA

Rellene el círculo así --> 

No así -->

Por favor conteste las siguientes preguntas.
Si Ud. necesita ayuda, comuníquese con la persona que le dio este formulario.

Inicial de su primer nombre: ☐

Inicial de su apellido: ☐

¿Qué género se considera Ud?
- O Hombre
- O Mujer
- O Transgénero: Hombre a Mujer
- O Transgénero: Mujer a Hombre
- O Otro

¿Cuál es su fecha de nacimiento? *(mm/dd/aa)*

☐☐ / ☐☐ / ☐☐

¿Cuál es el código postal de su hogar/lugar habitual donde socializa?

☐☐☐☐☐

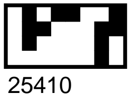
Para el próximo grupo de preguntas, por favor indique hasta dónde está de acuerdo o desacuerdo:

El SIDA ha sido casi curado.
- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo

Ser VIH positivo no es gran cosa ahora que los tratamientos son mejores.
- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo

Si Ud. es VIH-, ¿cuál cree que es su probabilidad de infectarse con VIH? Si Ud. es VIH+, ¿cuál cree que es su probabilidad de transmitir el VIH?
- O Muy probable
- O Probable
- O Ni Probable ni Improbable
- O Improbable
- O Muy Improbable

Soy capaz de usar condones bajo cualquier circumstancia para no infectarme o pasar el VIH. *(como cuando estoy borracho/a ó drogado/a ó cuando mi pareja no quiere usar condones)*
- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo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Cuestionario Auto-Administrado

Para el próximo grupo de preguntas, por favor indique si cree que la frase es verdadera o falsa:

	Verdadero	Falso	No Sé
Sacar el pene antes que el hombre alcance el clímax/eyacule, no deja que la mujer se infecte con VIH durante el sexo.	○	○	○
Hobres o mujeres se pueden infectar del VIH si tienen sexo anal con un hombre.	○	○	○
La gente que se infecta con el VIH muestra pronto señales serias de haberse Infectado.	○	○	○
Hay una vacuna que no deja que los adultos se infecten con el VIH.	○	○	○
Es probable que la gente se infecte con el VIH al besar profundamente ó poner la lengua en la boca de su pareja, si su pareja tiene el VIH.	○	○	○
Tener relaciones con más de una pareja puede aumentar la probabilidad que una persona se infecte con el VIH.	○	○	○

¡Gracias!

Sus respuestas serán confidenciales.
Sus respuestas ayudarán a nuestra agencia a servirle mejor.
Si Ud tiene alguna pregunta o inquietud por estas preguntas o sus respuestas, puede hablar con su facilitador de grupo.

Sección Administrativo: Esta sección debe ser completada por un/a trabajador/a de la agencia.

Intervention Type:

- ○ Individual Level Intervention (IDI)
- ○ Comprehensive Risk Counseling Service (CRCS)
- ○ Group

Date: *(mm/dd/yy)*

☐☐ / ☐☐ / ☐☐

Session:

- ○ Session 1
- ○ Final Session
- ○ 30 Fay Follow Up
- ○ 60 Day Follow Up

Program ID: ☐☐☐☐

Site ID: ☐☐☐☐