



**IV. Referrals**  (1) No Referrals Provided

	Agency:	Outcome:	
<input type="checkbox"/> (1) HIV Risk Reduction Activities	_____	_____	Provider Notes:
<input type="checkbox"/> (1) Pre-Exposure Prophylaxis (PrEP)	_____	_____	
<input type="checkbox"/> (1) HIV Medication Adherence Services	_____	_____	
<input type="checkbox"/> (1) Substance Use Services	_____	_____	
<input type="checkbox"/> (1) Syringe Services Program	_____	_____	
<input type="checkbox"/> (1) STD Testing and Treatment	_____	_____	
<input type="checkbox"/> (1) Hepatitis Services	_____	_____	
<input type="checkbox"/> (1) Mental Health Services	_____	_____	
<input type="checkbox"/> (1) TB Testing and Treatment	_____	_____	
<input type="checkbox"/> (1) Housing Services	_____	_____	

**V. Risk Reduction/Behavioral Outcomes** (complete at first session, last session and 30 days after intervention)

Number of Vaginal or Anal Sex Partners for the Past 30 Days:	Number of Vaginal or Anal Sex Partners by Serostatus Sex Partners for the Past 30 Days:	Percentage of Condom Use During Vaginal or Anal Sex by Serostatus Sex Partners for the Past 30 Days:
_____ Male	_____ Positive Partners	_____ % with HIV Positive Partners
+ _____ Female	+ _____ Negative Partners	_____ % with HIV Negative Partners
+ _____ Transgender	+ _____ Partners with Unknown Status	_____ % with HIV Unknown Partners
= _____ <b>TOTAL</b>	= _____ <b>TOTAL</b>	

**VI. HIV Medical Care Status** (complete for clients who are positive or preliminary positive)

<b>Has Client Ever Been in HIV Medical Care?</b> <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Did Not Ask <input type="checkbox"/> (9) D/R <b>If yes:</b> Clinic: _____ If yes: Date of Last HIV Medical Care Visit (mm/yyyy): _____ Date of Next HIV Medical Care Visit (mm/yyyy): _____ <input type="checkbox"/> No Appointment Scheduled Currently on Antiretrovirals (ARVs)? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No Last Known CD4: _____, _____ % Date (mm/yyyy): _____ Last Known Viral Load: _____ Date (mm/yyyy): _____ Source: <input type="checkbox"/> (1) Self-Report <input type="checkbox"/> (2) Healthcare Provider or <input type="checkbox"/> Check here if undetectable			
<b>Was Client Referred to HIV Medical Care?</b> <input type="checkbox"/> (1) Provider Referred Client to HIV Medical Care: <input type="checkbox"/> (2) Provider Referred Client to Program that does Linkage/Re-engagement to Care: <input type="checkbox"/> (3) No Referral Made Because: <input type="checkbox"/> (1) Client Currently in Care <input type="checkbox"/> (2) Referred at Previous Session <input type="checkbox"/> (3) Client Declined Referral (specify reason): _____ <input type="checkbox"/> (4) Other Reason (specify): _____	<b>Agency:</b> _____ _____	<b>Outcome:</b> _____ _____	<b>Date of Medical Visit (mm/dd/yyyy):</b> _____ _____
<b>If Positive and Female, is Client Pregnant:</b> <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't Know <input type="checkbox"/> (9) D/R If yes, in prenatal care: <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't Know <input type="checkbox"/> (9) D/R If no, was client referred to prenatal care: <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No			

**VII. HIV Medical Adherence**

<b>In the Last Three Days, Not Including Today, How Many Days Did Client Take Their ART Medication at Times and in the Amounts Prescribed by Their Doctor:</b> <input type="checkbox"/> (0) Zero <input type="checkbox"/> (1) One <input type="checkbox"/> (2) Two <input type="checkbox"/> (3) Three <b>Percent of ART Doses Taken in the Past Four Weeks:</b> _____ % As of (mm/dd/yyyy): _____	<b>Check if Adherence Support Provided During This Session:</b> <input type="checkbox"/> (1) Yes <b>Adherence Notes:</b> _____ _____
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**VIII. Partner Services**

<b>Was Partner Services Discussed/Offered This Session</b> (check one): <input type="checkbox"/> (1) Offered and Accepted <input type="checkbox"/> (2) Offered and Refused <input type="checkbox"/> (3) Not Offered <b>Was Skill Building Provided for Self-Notification:</b> <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No If yes, number of partners to be self-notified (0-999): _____ <b>Was Client Interviewed for Partner Elicitation at This Agency</b> (dual and 3rd party): <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <b>If yes,</b> interview date (mm/dd/yyyy): _____ (attach Partner Information Forms) If yes, number of partners (dual and 3rd party) (0-999): _____	<b>Was Partner Services Referred Out to Another Agency:</b> <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <b>If yes,</b> specify agency: _____ <b>If yes,</b> was client interviewed for partner elicitation: <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't Know If yes, interview date (mm/dd/yyyy): _____ If yes, number of partners (dual and 3rd party) (0-999): _____
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