

Louisiana Office of Public Health STD/HIV Form–Part 1

Revised December 2018

P 823600		Date of Session/ Visit										Rapid Testing															
Agency and Site Information				M	M	D	D	Y	Y	Y	Y	Worker ID															
Agency ID:				Risk behavior questions								Test 1		Test 2		Test 3		Test 4									
Site ID:				<i>In the past five years, have you</i>								Yes		No		Test Election		Test Election		Test Election		Test Election					
Client Information				Had oral, anal, or vaginal sex with a man								<input type="radio"/>		<input type="radio"/>		<input type="radio"/> HIV <input type="radio"/> Syphilis <input type="radio"/> Hep. C		<input type="radio"/> HIV <input type="radio"/> Syphilis <input type="radio"/> Hep. C		<input type="radio"/> HIV <input type="radio"/> Syphilis <input type="radio"/> Hep. C		<input type="radio"/> HIV <input type="radio"/> Syphilis <input type="radio"/> Hep. C					
Last Name:				Had oral, anal, or vaginal sex with a woman								<input type="radio"/>		<input type="radio"/>		Rapid Type:		Rapid Type:		Rapid Type:		Rapid Type:					
First Name:				Had oral, anal, or vaginal sex with a transgender partner								<input type="radio"/>		<input type="radio"/>		Test Result		Test Result		Test Result		Test Result					
Address:				Had sex with a person living with HIV								<input type="radio"/>		<input type="radio"/>		<input type="radio"/> Positive <input type="radio"/> Ag <input type="radio"/> Ab <input type="radio"/> Ag/Ab <input type="radio"/> Negative <input type="radio"/> Invalid		<input type="radio"/> Positive <input type="radio"/> Ag <input type="radio"/> Ab <input type="radio"/> Ag/Ab <input type="radio"/> Negative <input type="radio"/> Invalid		<input type="radio"/> Positive <input type="radio"/> Ag <input type="radio"/> Ab <input type="radio"/> Ag/Ab <input type="radio"/> Negative <input type="radio"/> Invalid		<input type="radio"/> Positive <input type="radio"/> Ag <input type="radio"/> Ab <input type="radio"/> Ag/Ab <input type="radio"/> Negative <input type="radio"/> Invalid					
City:		State:		Zip:		Injected any drugs, hormones, steroids, medications or substances								<input type="radio"/>		<input type="radio"/>		Rapid results provided to client?		<input type="radio"/> Yes		<input type="radio"/> No					
Phone:				Shared any injection equipment								<input type="radio"/>		<input type="radio"/>		Lab-based Testing											
Email:				PrEP Awareness and Use								Worker ID <input type="radio"/> same as rapid															
Date of Birth				M	M	D	D	Y	Y	Y	Y	<i>Please answer the following:</i>		Yes		No		Test Performed (mark <input type="radio"/> all that apply)				Yes		No			
Race / Ethnicity (mark <input type="radio"/> all that apply)				Have you ever heard of PrEP?								<input type="radio"/>		<input type="radio"/>		HIV				<input type="radio"/>		<input type="radio"/>					
<input type="radio"/> AK Native/Native American		<input type="radio"/> Native HI/Pac. Islander		Are you currently taking PrEP medication?								<input type="radio"/>		<input type="radio"/>		Syphilis				<input type="radio"/>		<input type="radio"/>					
<input type="radio"/> Asian		<input type="radio"/> White		Have you used PrEP in the last 12 months?								<input type="radio"/>		<input type="radio"/>		Hepatitis C				<input type="radio"/>		<input type="radio"/>					
<input type="radio"/> Black/African American		<input type="radio"/> Don't know		Are you interested in PrEP?								<input type="radio"/>		<input type="radio"/>		Other:				<input type="radio"/>		<input type="radio"/>					
<input type="radio"/> Hispanic/Latino/Latinx		<input type="radio"/> Other: _____		Referred to PrEP provider?								<input type="radio"/>		<input type="radio"/>		Gonorrhea/Chlamydia				<input type="radio"/> Oral		<input type="radio"/> Anal		<input type="radio"/> Urine			
Gender Identity (mark <input type="radio"/> all that apply)				During the session, does client need																							
<input type="radio"/> Woman		<input type="radio"/> Transgender man		Health insurance enrollment								<input type="radio"/>		<input type="radio"/>													
<input type="radio"/> Man		<input type="radio"/> Transgender woman		Evidence-based risk reduction interventions								<input type="radio"/>		<input type="radio"/>													
<input type="radio"/> Client identifies as: _____				Behavioral health services								<input type="radio"/>		<input type="radio"/>													
Assigned Sex at Birth?		<input type="radio"/> Female <input type="radio"/> Male		Social Services								<input type="radio"/>		<input type="radio"/>													
Has client previously been tested? (mark all that apply)																											
HIV		<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Don't know																									
If Positive, date diagnosed? ____/____/____		<input type="radio"/> In care																									
Syphilis		<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Don't know																									
If Positive, date treated? ____/____/____		<input type="radio"/> Not treated																									
Hep. C		<input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Don't know																									
If Positive, date treated? ____/____/____		<input type="radio"/> Not treated																									
No previous testing:		<input type="radio"/> HIV <input type="radio"/> Syphilis <input type="radio"/> Hep. C																									

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