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# SAMHSA MAI Rapid HIV/HEPATITIS Testing Clinical Information Form

<b>SECTION A: SITE CHARACTERISTICS</b>		1. Date of visit (mm/dd/yyyy): _____	
2. Grantee #: _____		3. Partner ID (if applicable): _____	
4. CLIENT RHHT ID #: _____		5. GPRA ID #: _____ <input type="checkbox"/> GPRA Tool Not Completed	
6. Site type code # (see site code on back page) _____			
<b>RAPID HIV TEST KIT LOT NUMBER:</b> _____			
<b>SECTION B: DEMOGRAPHICS</b>			
<b>1. Gender (check one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>3. Race (check all that apply)</b> <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> White	<b>4. Age (check one)</b> <input type="checkbox"/> <18 yrs <input type="checkbox"/> 18-24 yrs <input type="checkbox"/> 25-34 yrs <input type="checkbox"/> 35-44 yrs <input type="checkbox"/> 45-54 yrs <input type="checkbox"/> 55-64 yrs <input type="checkbox"/> 65+ yrs	<b>5. Previous HIV Test</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes: (check one)</b> <input type="checkbox"/> Result was negative <input type="checkbox"/> Result was positive <input type="checkbox"/> Result was inconclusive <input type="checkbox"/> Result was unknown
<b>6. Previous Viral Hepatitis Test</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes: (check one)</b> <input type="checkbox"/> Result was negative <input type="checkbox"/> Result was positive <input type="checkbox"/> Result was inconclusive <input type="checkbox"/> Result was unknown			
<b>SECTION C: RISK BEHAVIORS</b>			
<b>1. During the past 30 days have you - from the date of this form (check all that apply)</b>			
<input type="checkbox"/> had unprotected sex with a male <input type="checkbox"/> had unprotected sex with a female <input type="checkbox"/> had unprotected sex with a transgender individual <input type="checkbox"/> had unprotected sex with significant other in a monogamous relationship <input type="checkbox"/> had unprotected sex with multiple partners <input type="checkbox"/> had unprotected sex with an HIV positive person <input type="checkbox"/> had unprotected sex with an Hepatitis positive person		<input type="checkbox"/> had unprotected sex with a person who injects drugs <input type="checkbox"/> had unprotected sex with a man who has sex with men <input type="checkbox"/> exchanged sex for drugs/money/shelter <input type="checkbox"/> been diagnosed with sexually transmitted disease (syphilis, chlamydia, gonorrhea, herpes) <input type="checkbox"/> refusal <input type="checkbox"/> the client reports no known sexual risk factors	
<b>2. During the past 30 days have you used: from the date of this form (check all that apply)</b>			
<input type="checkbox"/> 4 or more alcoholic drinks in 1 sitting ( <b>for men</b> ) <input type="checkbox"/> 3 or more alcoholic drinks in 1 sitting ( <b>for women</b> ) <input type="checkbox"/> cocaine (crack)		<input type="checkbox"/> marijuana <input type="checkbox"/> ecstasy <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> inhalants (specify) _____	
		<input type="checkbox"/> non-medical use of prescription drugs <input type="checkbox"/> shared injection equipment (i.e. needle and drug paraphernalia) <input type="checkbox"/> refusal <input type="checkbox"/> the client reports no known substance use risk factors <input type="checkbox"/> other (specify) _____	
<b>3. Have you (check all that apply)</b>			
<input type="checkbox"/> been diagnosed with alcohol or drug dependence, in the past 12 months <input type="checkbox"/> been in alcohol or drug treatment in the past 12 months <input type="checkbox"/> ever been in alcohol or drug treatment		<input type="checkbox"/> been diagnosed with psychological distress, in the past 12 months (e.g., major depression, anxiety disorder) <input type="checkbox"/> ever received treatment for psychological distress during the past 12 months? (e.g., major depression, anxiety disorder) <input type="checkbox"/> none of the above	
<b>SECTION D: Rapid HIV TESTING RESULTS</b>		<b>SECTION E: Rapid HEPATITIS B &amp; C TESTING RESULTS, if applicable</b>	
<b>1. Rapid HIV test result (check one)</b>		<b>1. Rapid Hepatitis test results (check all that apply)</b>	
<input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid (Repeat test)		<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid (Repeat test) <input type="checkbox"/> Refusal	
<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Refusal		<input type="checkbox"/> Hepatitis C <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid (Repeat test) <input type="checkbox"/> Refusal	
<b>2. Did client receive result of rapid HIV test? (check one)</b>		<b>2. Did client receive results of rapid HEP test? (check one)</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Hep B</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hep C</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3. Retest HIV Result: (check one)</b>		<b>3. Retest HEP Result: (check one)</b>	
<input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid/Indeterminate		<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid (Repeat test) <input type="checkbox"/> Refusal	
<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> N/A		<input type="checkbox"/> Hepatitis C <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-reactive <input type="checkbox"/> Invalid (Repeat test) <input type="checkbox"/> Refusal	
<b>4. Did client receive retest result of test? (check one)</b>		<b>4. Did client receive retest results of test? (check one)</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Hep B</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hep C</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

