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SAMHSA MAI Rapid HIV/HEPATITIS Testing Clinical Information Form

| | | | |
|---|---|--|--|
| SECTION A: SITE CHARACTERISTICS | | 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) _____ | | | |
| RAPID HIV TEST KIT LOT NUMBER: _____ | | | |
| SECTION B: DEMOGRAPHICS | | | |
| 1. Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender | 3. Race (check all that apply) <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 | 4. Age (check one) <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 | 5. Previous HIV Test <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: (check one) <input type="checkbox"/> Result was negative <input type="checkbox"/> Result was positive <input type="checkbox"/> Result was inconclusive <input type="checkbox"/> Result was unknown |
| 6. Previous Viral Hepatitis Test <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: (check one) <input type="checkbox"/> Result was negative <input type="checkbox"/> Result was positive <input type="checkbox"/> Result was inconclusive <input type="checkbox"/> Result was unknown | | | |
| SECTION C: RISK BEHAVIORS | | | |
| 1. During the past 30 days have you - from the date of this form (check all that apply) | | | |
| <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 | |
| 2. During the past 30 days have you used: from the date of this form (check all that apply) | | | |
| <input type="checkbox"/> 4 or more alcoholic drinks in 1 sitting (for men) <input type="checkbox"/> 3 or more alcoholic drinks in 1 sitting (for women) <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) _____ | | | |
| 3. Have you (check all that apply) | | | |
| <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 | |
| SECTION D: Rapid HIV TESTING RESULTS | | SECTION E: Rapid HEPATITIS B & C TESTING RESULTS, if applicable | |
| 1. Rapid HIV test result (check one) | | 1. Rapid Hepatitis test results (check all that apply) | |
| <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 | |
| 2. Did client receive result of rapid HIV test? (check one) | | 2. Did client receive results of rapid HEP test? (check one) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | Hep B <input type="checkbox"/> Yes <input type="checkbox"/> No Hep C <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Retest HIV Result: (check one) | | 3. Retest HEP Result: (check one) | |
| <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 | |
| 4. Did client receive retest result of test? (check one) | | 4. Did client receive retest results of test? (check one) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | Hep B <input type="checkbox"/> Yes <input type="checkbox"/> No Hep C <input type="checkbox"/> Yes <input type="checkbox"/> No | |

