**Form Approved**

**OMB No. 0920-New**

**Expiration Date XX/XX/XXXX**

**Prevent Hepatitis Transmission among Persons Who Inject Drugs**

**Attachment 3A
Screener Instrument**

**Form Approved**

**OMB No. 0920-New**

**Expiration Date XX/XX/XXXX**

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

**Study Screening Form**

**Today’s DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**CONFIDENTIAL Initial Screening Questionnaire**

##### A BIG “THANK YOU” FOR YOUR INTEREST IN THIS STUDY

##### Fill in as much information as you can now. A Vale worker will review the form with you after you turn it in.

**How did you hear about Vale?**

**What is your date of birth?** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_

**What is your mother’s first name?**

**Do you have any pets? YES / NO**

**If YES, Circle: DOG / CAT / OTHERS**

**How long have you been in (study area)? \_\_\_\_\_\_\_\_\_\_\_ mos/years.**

**How long do you intend to stay? \_\_\_\_\_\_\_\_\_\_\_ mos/years.**

**Have you received any medical care in the LAST WEEK? YES / NO**

**Have you ever had an STD test? YES / NO**

**If YES, what was the most recent result?**

**Have you ever had an HIV test? YES / NO**

**If YES, CIRCLE the most recent result: POS / NEG / INDET / DIDN’T FIND OUT**

**Have you ever had a measles vaccine? YES / NO / DON’T KNOW**

**Do you have any allergies? YES / NO**

**If yes, what are you allergic to?**

**Do you inject drugs or anything else? YES / NO**

**If YES, when was the last time you injected anything?** Today

In the last week In the last 30 days In the last 6 months

More than 6 months ago Never Really can’t remember