Intake- Client Information

Please complete the questions below as accurately as possible

Client ID _____ Testing Staff Only

Test Date _____/_____/_____ MM/DD/YYYY

First Name _____ Last Name _____

Middle Name/Initial _____ Pronouns _____

Preferred Name _____

Date Of Birth _____/_____/_____ MM/DD/YYYY

Phone Number (_____)_____-_____

Phone Type:
- ☐ Cell
- ☐ Work
- ☐ Other

Okay to receive text? ☐ Yes ☐ No

Okay to receive voicemail? ☐ Yes ☐ No

Address _____ Street Address

_____ City State Zip

What county do you live in? _____

Email _____

Okay to receive email? ☐ Yes ☐ No

Please provide any additional information here about how you may be reached in addition to the information provided above, if applicable. This can include an emergency contact or alternate contact person, and may also include any social media handles you may use.

Race and Ethnicity Information

Do you consider yourself Hispanic or Latino/a/x?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

What race or races do you consider yourself?
You can be as broad or specific as you'd like (check all responses)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Not Specified
- ☐ Don't Know

Preferred Language: _____

Other: _____

(See Extended Race Sheet for more options)

Gender & Sexual Orientation Information

What was your sex assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Declined to answer
- ☐ Unknown

What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Nonbinary
- ☐ Genderqueer
- ☐ Transgender Female/Transfeminine
- ☐ Transgender Male/Transmasculine
- ☐ Other
- ☐ Unknown

Which most closely describes the your sexual orientation?

- ☐ Straight or heterosexual
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Another or a different sexual orientation
- ☐ Declined to answer
- ☐ Don't Know

Are you currently pregnant?

☐ Yes ☐ No ☐ Don't Know ☐ N/A

Medical Insurance Information

Do you have insurance? If so, what kind of insurance do you have?

☐ No insurance
☐ Employer / union provided
☐ Self-purchased Plan
☐ Medicare
☐ Medicaid (Apple Health)
☐ Apple Health for Children (CHIP)
☐ TRICARE / VA / CHAMPUS
☐ Indian Health Service
☐ Other government Plan
☐ Don't Know

Do you have a medical provider or doctor that you consider your primary provider?

☐ Yes ☐ No ☐ Don't Know

Client History

Have you had sex with a male? If so, when was the last time?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you had sex with a female? If so, when was the last time?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you had sex with a transgender person?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you exchanged sex for anything of value (eg: money, shelter, food, drugs, goods).
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you had sex without a condom with multiple partners?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever injected drugs or other substances not prescribed by a medical provider?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever used drugs, not prescribed by a medical provider, in other ways (eg: snorting, smoking) ?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever used drugs or substances before or during sex not prescribed by a medical provider?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever been incarcerated (jail, prison)?
☐ Less than 1 year ago ☐ Between 1 to 5 years ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Testing History

Have you ever had an HIV test? If so, what was the result? What year were you diagnosed with HIV?

☐ Negative ☐ Positive ☐ Not Tested ☐ Don't Know Year:_____ ☐ Date Unknown

Are you currently taking HIV medication? ☐ Currently Taking Medication ☐ Not Currently Taking Medication

Have you ever had an HCV test? If so, what was the result? ☐ Negative ☐ Positive ☐ Not Tested ☐ Don't Know

Have you ever received treatment for HCV? ☐ Yes ☐ No ☐ Don't Know

Have you ever been diagnosed with chlamydia? If so, when was the most recent time?
☐ Less than 1 year ago ☐ Between 1 to 5 years Ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever been diagnosed with gonorrhea? If so, when was the most recent time?
☐ Less than 1 year ago ☐ Between 1 to 5 years Ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever been diagnosed with syphilis? If so, when was the most recent time?
☐ Less than 1 year ago ☐ Between 1 to 5 years Ago ☐ More than 5 years ago ☐ Never ☐ Don't Know

Have you ever received treatment for syphilis? ☐ Yes ☐ No ☐ Don't Know

PrEP & PEP History

Have you ever heard of HIV Pre-Exposure Prophylaxis or PrEP? ☐ Yes ☐ No

Have you ever heard of HIV Post-Exposure Prophyaxis of HIV PEP? ☐ Yes ☐ No

Have you ever used PrEP? If so, are you currently using PrEP? ☐ Currently on PrEP ☐ PrEP discontinued within past 12 months ☐ Never taken PrEP

List of Preferred Languages

Language Identity Codes:

(L01) Amharic
(L02) Arabic
(L03) Balochi/Baluchi
(L04) Burmese
(L05) Cantonese
(L06) Chinese
(L07) Chamorro
(L08) Chuukese
(L09) Dari
(L10) Farsi/Persian
(L11) Fijian
(L12) Filipino/Pilipino
(L13) French
(L14) German
(L15) Hindi
(L16) Hmong
(L17) Japanese
(L18) Karen
(L19) Khmer/ Cambodian
(L20) Kinyarwanda
(L21) Korean
(L22) Kosraean
(L23) Lao
(L24) Mandarin
(L25) Marshallese
(L26) Mixteco
(L27) Nepali
(L28) Oromo
(L29) Panjabi/ Punjabi
(L30) Pashto
(L31) Portuguese
(L32) Romanian/ Rumanian
(L33) Russian
(L34) Samoan
(L35) Sign Languages
(L36) Somali
(L37) Spanish/ Castillian
(L38) Swahili/ Kiswahili
(L39) Tagalog
(L40) Tamil
(L41) Telugu
(L42) Thai
(L43) Tigrinya
(L44) Ukranian
(L45) Urdu
(L46) Vietnamese
(L77) Other Language
(L88) Paitient declined to respond
(L99) Unknown

Race Category and Identity Instructions:

Extended Race Codes:

(R01) Afghan
(R02) Afro-Caribbean
(R03) Alaska Native
(R04) American Indian
(R05) Arab
(R06) Asian
(R07) Asian Indian
(R08) Bamar/Burman/Burmese
(R09) Bangladeshi
(R10) Bhutanese
(R11) Black or African American
(R12) Central American
(R13) Cham
(R14) Chicana/o or Chicanx
(R15) Chinese
(R16) Congolese
(R17) Cuban
(R18) Dominican
(R19) Egyptian
(R20) Eritrean
(R21) Ethiopian
(R22) Fijian
(R23) Filipino
(R24) First Nations
(R25) Guamanian or Chamorro
(R26) Hmong/Mong
(R27) Indigenous-Latina/o/x
(R28) Indonesian
(R29) Iranian
(R30) Iraqi
(R31) Japanese
(R32) Jordanian
(R33) Karen
(R34) Kenyan
(R35) Khmer/Cambodian
(R36) Korean
(R37) Kuwaiti
(R38) Lao
(R39) Lebanese
(R40) Malaysian
(R41) Marshallese
(R42) Mestizo
(R43) Mexican/Mexican American
(R44) Middle Eastern
(R45) Mien
(R46) Moroccan
(R47) Native Hawaiian
(R48) Nepalese
(R49) North African
(R50) Oromo
(R51) Pacific Islander
(R52) Pakistani
(R53) Puerto Rican
(R54) Romanian/Rumanian
(R55) Russian
(R56) Samoan
(R57) Saudi Arabian
(R58) Somali
(R59) South African
(R60) South American
(R61) Syrian
(R62) Taiwanese
(R63) Thai
(R64) Tongan
(R65) Ugandan
(R66) Ukrainian
(R67) Vietnamese
(R68) White
(R69) Yemeni
(R77) Other race
(R99) Unknown

Test Event Information

Site Name

Client ID

Funding Source

Client Information

First Name

Last Name

Middle Name/ Middle Initial

Referral Source

What led the client to seek testing (referral method)?

- ☐ Community Organization
- ☐ Medical Provider
- ☐ Partner
- ☐ Public Health Notification
- ☐ Social Media
- ☐ Syringe Exchange Program
- ☐ Word of Mouth
- ☐ Other: _____

Integrated Infectious Disease Testing

Was an HIV test performed? ☐ Yes ☐ No Specimen Collection Date: _____/_____/_____

Rapid Type: ☐ Chembio Dual HIV/Syphilis Rapid ☐ bioLytical INSTI ☐ Abbott Determine ☐ Sure Check ☐ Other

Result: ☐ Preliminary Positive ☐ Negative ☐ Discordant ☐ Invalid

HIV Testing

Blood-draw Date: _____/_____/_____

Test Election:
☐ Confidential ☐ Anonymous*

HIV-1/HIV-2 Ab differentiation:

- ☐ HIV-1 Antibodies Detected (only)
- ☐ HIV-2 Antibodies Detected (only)
- ☐ HIV-1 and HIV-2 Ab Detected (Dualinfection)
- ☐ Negative
- ☐ Inconclusive
- ☐ Further testing needed

HIV 1/2 antibody/antigen (p24) / antibody immunoassay:
☐ Positive ☐ Negative

RNA (NAT) Testing:
☐ Positive ☐ Negative

Final Result Interpretation:

- ☐ Preliminary Positive HIV-1/HIV-2
- ☐ HIV-1 Positive
- ☐ HIV-1 Positive, possible acute
- ☐ HIV-2 Positive
- ☐ HIV Positive, undifferentiated
- ☐ HIV-1 Negative
- ☐ HIV-2 inconclusive
- ☐ HIV-1 Negative
- ☐ HIV Negative
- ☐ Inconclusive

Results provided to client:
☐ Yes ☐ No

*Coinfection testing only available in conjunction with confidential HIV tests: A single test event can be used to report both an HIV test and coinfection testing only if the client elected for a confidential HIV test. State law does not allow for anonymous chlamydia, gonorrhea, syphilis and/or hepatitis testing. Agencies must report coinfection testing on a separate test event if the client elected for an "anonymous" HIV test

Additional Testing Information (CT/GC/Syphilis/HCV)

Did the client receive tests for other STIs or HCV? ☐ Yes ☐ No

Check all coinfection tests performed during the event:
☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Hepatitis C

Specimen Collection Date:
_____/_____/_____

Additional Testing Information

Chlamydia

Speciman Type: Urine

Result:
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Speciman Type: Swab

Anatomical Site: Pharynx
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Anatomical Site: Vagina
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Anatomical Site: Rectum
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Gonorrhea

Speciman Type: Urine

Result:
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Speciman Type: Swab

Anatomical Site: Pharynx
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Anatomical Site: Vagina
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Anatomical Site: Rectum
☐ Positive ☐ Negative ☐ Not Offered ☐ Declined

Hepatitis C

HCV Antibody:

Type
☐ Rapid (Point of Care) ☐ Lab-Based (Blood Draw)

Result:
☐ Positive / Reactive ☐ Negative / Non-reactive

HCV RNA:

Type
☐ Rapid (Point of Care) ☐ Lab-Based (Blood Draw)

Result:
☐ Positive / Reactive ☐ Invalid/Indeterminate
☐ Negative / Non-reactive ☐ Other

Syphilis

Rapid (Point of Care) Test:

Rapid Type:
☐ Syphilis Health Check ☐ Chembio Dual HIV/Syphilis Rapid ☐ Other

Result:
☐ Positive / Reactive ☐ Negative / Non-reactive ☐ Other

Laboratory-Based Test:

RPR (non-treponemal):
☐ Positive / Reactive ☐ Negative / Non-reactive ☐ Other

RPR (non-treponemal) Titer

☐ Titer 1:1
☐ Titer 1:2
☐ Titer 1:4
☐ Titer 1:8
☐ Titer 1:16
☐ Titer 1:32
☐ Titer 1:64
☐ Titer 1:128
☐ Titer 1:256
☐ Titer 1:512
☐ Titer 1:1024
☐ Titer 1:2048
☐ Titer 1:4096
☐ Titer 1:8192
☐ Titer 1:16,382
☐ Titer 1:32,764

EIA/CIA (treponemal Ab):
☐ Positive ☐ Negative ☐ Pending

TPPA:
☐ Positive / Reactive ☐ Negative / Non-reactive

Final Status:
☐ Confirmed - New/Untreated Infection*
☐ Confirmed - Treated
☐ Confirmed - Not Infected
☐ Other

*Consultation with LHJ required to determine if client is confirmed infected or confirmed with previously treated infection.

Treatment *(Optional)*

Chlamydia / Gonorrhea:

Date Treated: _____/_____/_____

Medication (check all that apply):

- ☐ Azithromycin 1g
- ☐ Doxycycline 100 mgBID x 7 days
- ☐ Ceftriaxone 500 mg
- ☐ Other Treatment
- ☐ Not Treated

Other Treatment / Treatment Notes:

Syphilis:

Date Treated: _____/_____/_____

Medication (check all that apply):

- ☐ Not treated
- ☐ Bicillin L - A: 2.4 MU IM x1
- ☐ Bicillin L - A: 2.4 MU IM x 3
- ☐ Doxycycline: 100 mg BID x 14 days
- ☐ Doxycycline: 100 mg BID x 28 days
- ☐ Other Treament

Other Treatment / Treatment Notes:

Hepatitis C:

Medication:

- ☐ Mavyret (glecaprevir/pibrentasvir)
- ☐ Epclusa (sofosbuvir/velpatasvir)
- ☐ Harvoni (ledipasvir/sofosbuvir)
- ☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
- ☐ Sovaldi (sofosbuvir)
- ☐ Zepatier (elbasvir/grazoprevir)
- ☐ Other: _____
- ☐ Unknown

Date Prescribed (if known): _____/_____/_____

Treatment Start Date (if known): _____/_____/_____

Treatment Duration (if known): ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Treatment Outcome/Status: ☐ Ongoing ☐ Completed ☐ Discontinued ☐ Lost to follow-up ☐ Unknown

Did the client achieve sustained virologic response (SVR)? ☐ Yes ☐ No ☐ Unknown

Other Treatment / Treatment Notes:

Support Services

What was the client's most severe housing status in the last 12 months?

☐ Literally Homeless ☐ Unstably housed ☐ Stably housed ☐ Not asked ☐ Declined to answer ☐ Don't know

Housing Outcome

☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

In the last 12 months, have mental health needs significantly affected the client's health or well-being?

☐ Yes ☐ No ☐ Not Screened

Mental Health Outcome

☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

In the last 12 months, has substance use significantly affected the client's health or well-being?

☐ Yes ☐ No ☐ Not Screened

Substance Use Outcome

☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

Support Services

Does client need support accessing health insurance or other health benefits programs (PrEP DAP, rebate cards, etc.). Select all that apply
☐ Yes- PrEP DAP ☐ Yes- Rebate Cards ☐ Yes- Health Insurance ☐ No ☐ Not Screened

Health Benefits Outcome
☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

Did you discuss strategies for developing healthier sexual health practices?
☐ Yes ☐ No ☐ Not Screened

Risk Reduction Outcome
☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

Doxy PEP: Did you discuss need for doxycycline postexposure prophylaxis (doxy PEP)?
☐ Not aware of Doxy PEP ☐ Aware but never used Doxy PEP ☐ Used Doxy PEP in past 12 months ☐ Other ☐ Not Screened

Doxy PEP Outcome
☐ Services Not Provided ☐ Provided Service(s) ☐ Referred Out ☐ Client Declined

Is the client fully vaccinated against MPOX (MSM/TSM Only)?
☐ Completely vaccinated ☐ Incomplete/No vaccination ☐ Not at risk ☐ Not Assessed

Is the client eligible for PrEP?
☐ PrEP Eligible (Local/DOH) ☐ Not Eligible ☐ Not Screened

PrEP Outcome
☐ Rx Provided (Internal) ☐ Rx Provided (External) ☐ Referred to Provider
☐ Support Services Provided ☐ Client Declined ☐ Not Offered

Was the client provided education/information on PEP?
☐ Yes ☐ No

Can client benefit from PEP??
☐ Yes ☐ No

Linkage to or Re-engagement in HIV Medical Care (HIV Positive Only)

Was the client provided navigation or other linkage services to facilitate linkage to or re-engagement in HIV medical care?
☐ Yes ☐ No ☐ Don't Know

Did the client attend an HIV medical care appointment after session date?
☐ Yes, confirmed ☐ Yes, client/patient self-report ☐ No ☐ Don't know

If "Yes," date attended
_____/_____/_____

Antiretroviral Treatment (ART) (HIV Positive Only)

Did the client receive a prescription for HIV antiretroviral treatment (ART) after session date?
☐ Yes, confirmed ☐ Yes, client/patient self-report ☐ No ☐ Don't know

If "Yes," how long after session date did the client receive an ART prescription?
☐ ≤ 7 days ☐ 8-30 days ☐ 31-60 days ☐ 61-90 days ☐ ≥91 days ☐ Don't know

Additional Testing Notes:

Consent For Services (Required)

Privacy and Confidentiality

- Your personal information, what you tell us, and your test results are confidential and protected by law.
- Your test results may not be shared without your written permission, except for the reports described below. These reports are required by Washington state law.
- We send a record of your visit to the Washington State Department of Health (DOH), including your name and your test results. We send this whether your results are negative or positive. Keeping a complete record helps you get follow-up care if you ever need it and helps the state plan testing services.
- Positive results for certain infections are also reported to your local health department, as state law requires. They may contact you to help you get treatment and to talk about telling partners who may need testing. [If HIPAA-covered entity]: The testing agency's Notice of Privacy Practices explains how your personal information may be used and shared and is available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA).
- If non-HIPAA-covered entity]: The testing agency's privacy policy explains how your information may be used and shared. Ask us for a copy.
- If you have questions about how your information may be used or shared, please ask a staff member.

It has been explained to me how my information is used and where it is sent.

Initial: _____ **Date:** _____

Testing Procedures & Informed Consent

I understand that today's visit is for sexually transmitted infections (STIs), hepatitis C, and/or HIV testing, which may include one or more of the following:

- Blood collection by finger stick and/or blood draw
- Urine collection
- Oral swab collection
- Genital swab collection
- Rectal swab collection

I understand and acknowledge that:

- I have had an opportunity to ask questions and receive information about the testing process.
- Participation in testing is completely voluntary.
- Some results may be available during my visit, while others may require additional laboratory processing.
- Additional samples or testing may be needed to confirm some positive test results.
- If my test results indicate that additional care or treatment is recommended, I will be referred to a health-care provider, and my test results may be shared with my healthcare teams as permitted by law.

Signature

By signing this form, I voluntarily consent to testing for STIs, hepatitis C, and HIV, which may be offered as routine testing services. I understand that I may decline any test.

Client Name:_____ **Client Signature:**_____

Date: _____ **Staff Member:**_____

Notice of Privacy Practices Provided to Client: ☐ Yes ☐ Declined