

# Delaware HIV Counseling, Testing, and Referral (CTR) Form

Section 1 AGENCY USE ONLY		
Session Date:		Evaluation Web Form ID:
Agency Name:		Site Name:
Site County:		Site Zip:
Local Client ID:		
Tester Name:		
Section 2 CLIENT INFORMATION		
Year of Birth: (1800 if unknown)		Client State: Client Zip:
Client Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined		
Client Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Not Specified <input type="checkbox"/> Unknown <input type="checkbox"/> Declined		
Sex assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined		
Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Transgender – Male <input type="checkbox"/> Transgender – Not Specified <input type="checkbox"/> Female <input type="checkbox"/> Transgender – Female <input type="checkbox"/> Another Gender <input type="checkbox"/> Declined		
Previously Tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Section 3 FINAL TEST INFORMATION		
HIV Test Election <input type="checkbox"/> Confidential <input type="checkbox"/> Test not done		Point of Care (POC) Rapid Test Result <input type="checkbox"/> Negative <input type="checkbox"/> Discordant <input type="checkbox"/> Preliminary Positive
Was result provided to client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Section 4 NEGATIVE TEST RESULT		
Is client at risk for HIV infection? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Was client screened for PrEP eligibility? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Is client eligible for PrEP referral? <input type="checkbox"/> No <input type="checkbox"/> Yes, by CDC criteria <input type="checkbox"/> Yes, by local criteria or protocol	Was client referred to a PrEP provider? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Was the client provided with services to assist with the linkage to a PrEP Provider? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Section 5 POSITIVE TEST RESULT		
Has client ever had a positive HIV test? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	Did client attend post-test medical care appointment? <input type="checkbox"/> No <input type="checkbox"/> Yes, client self-reported <input type="checkbox"/> Don't know <input type="checkbox"/> Yes, confirmed	
If yes, date of first positive results: ____/____/____	If yes, date attended: ____/____/____	
Was client provided with individualized behavioral risk-reduction counseling? <input type="checkbox"/> No <input type="checkbox"/> Yes	Was client's contact information provided to the health department for Partner Services? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What was the client's most severe housing status in the last 12 months? <input type="checkbox"/> Literally homeless <input type="checkbox"/> Stably housed <input type="checkbox"/> Unstably housed and at-risk of losing housing <input type="checkbox"/> Not asked <input type="checkbox"/> Declined to answer <input type="checkbox"/> Don't know		

*(Females Only) Is the client pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown		*(If pregnant) Is the client receiving prenatal care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Unknown	
*(If pregnant) Was the client screened for the need of perinatal HIV service coordination? <input type="checkbox"/> No <input type="checkbox"/> Yes		*(If pregnant) Does the client need perinatal HIV service coordination? <input type="checkbox"/> No <input type="checkbox"/> Yes	
*(If pregnant) Was the client referred for perinatal service coordination? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Section 6 ADDITIONAL TESTS			
Was the client tested for co-infections? <input type="checkbox"/> No (skip to Section 7) <input type="checkbox"/> Yes (see below)			
Tested for Syphilis? <input type="checkbox"/> No <input type="checkbox"/> Yes Syphilis test result (if tested): <input type="checkbox"/> Negative <input type="checkbox"/> Newly identified infection <input type="checkbox"/> Not Known		Tested for Gonorrhea? <input type="checkbox"/> No <input type="checkbox"/> Yes Gonorrhea test result (if tested): <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Known	
Tested for Chlamydia? <input type="checkbox"/> No <input type="checkbox"/> Yes Chlamydia test result (if tested): <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Known		Tested for Hepatitis C? <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis C test result (if tested): <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Known	
Section 7 PrEP Awareness/Use/Population			
Has the client <b>ever heard of PrEP</b> (Pre-Exposure Prophylaxis)? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Is the client currently <b>taking daily PrEP</b> medication? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Has the client <b>used PrEP</b> any time in the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes			
In the past 5 years, has the client had <b>sex with a male</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes			
In the past 5 years, has the client had <b>sex with a female</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes			
In the past 5 years, has the client had <b>sex with a transgender person</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes			
In the past 5 years, has the client <b>injected drugs or substances</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Section 8 Essential Support Services (complete for all clients except as indicated)			
*First (3) for HIV positive cases only	Screened for need	Need determined	Provided or referred
Navigation for HIV related medical care*	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Linkage to HIV medical care*	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medication adherence support*	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Health benefits navigation & enrollment	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Evidence based risk reduction	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Behavioral Health	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Social Services	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Notes:			