Infectious Disease Risk Assessment

The Infectious Disease Risk Assessment Form is to be completed following the Comprehensive Assessment by all programs that receive Department of Public Health funding or others who wish to utilize it. This assessment is best conducted in an interview type manner by a clinically trained person who has some familiarity with HIV and other sexually transmitted diseases, HIV testing sites and other resources. At a minimum, agencies should provide staff conducting this assessment with a one page fact sheet on HIV that includes basic facts about HIV and a list of local testing sites. It is recommended that a fact sheet on Hepatitis C also be created as an adjunct to the HIV fact sheet. The DPH website has materials prepared in multiple languages.

Data Field	Person Served Demographic Information
Person's Name	Person should be informed that recording their name is optional on this form. If person agrees, record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
DOB	Record the person's date of birth.
Gender	Record the person's gender. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Drug Use / Route**
1. **What drugs do you usually use?** 2. **How do you use your drugs?**	Check all drugs which the person reports use. Check all applicable routes of use for the drugs checked in question 1.
Data Field	**Needle Use (for non-IV drug users check N/A for questions 3-6**
3. If you inject drugs, how often do you use new needles?	If person injects drugs, ask how often new needles are used and check the box indicated. If response is anything other than always, inform person that even if cleaning needles (his/her own or someone else's), there is still a risk of getting infections. Review where new needles may be obtained (i.e. pharmacy, needle exchange programs).
4. If you use new needles, where do you get them?	Check all applicable sources of new needles for the person and review underutilized resources as applicable.
5. If you use needles, how do you dispose of them?	Check all applicable disposal methods and review with person the importance of safe disposal in order to reduce the risk of harm or infection to self and others. Review best practices of needle disposal and options available to the person as applicable.
6. Do you ever share needles/injection equipment?	Check yes, no or not applicable. Inform the person that risk of infection is possible not only through shared needle use, but also through sharing of other injection equipment (i.e. water, spoons, etc.).
Data Field	**Sexual Activity**
7. In the last five years, about how many people have you had sex with?	Check the box that reflects the approximate number of sexual partners / encounters in the past five years. Sexual contact includes both intercourse and oral sex for the purpose of this question.
8. How often do you use protection against infections?	If the person reports long term abstinence, check N/A. Otherwise, check frequency of use of protection and review risks involved with unprotected sex and forms of protection as applicable.
9. Have you had sex for money, drugs or something	Check yes or no based on the person's response. If yes, discuss alternatives to getting needs met as appropriate.

you needed?	
Data Field	**HIV Testing / Resources / Recommendations**
10. When was the last time you were tested for HIV?	Indicate date of last HIV test or never.
11. Did you receive your results?	Indicate N/A or whether the person received results from their last HIV test. If the person did not receive results, have conversation about what prevented this and offer assistance as applicable.
12. Would you like more information about HIV where to get tested / treated?	Ask the person if they have questions about HIV, other Sexually Transmitted Diseases or testing. Check the corresponding box. Provide the person with desired information or referrals.
Please check what was provided to Person Served below:	Check and record information provided to the person or check "discussion only" if no other information was given.
Other Notes / Recommendations	Record any other pertinent information or specifics related to recommendations given to the person in this section.
Data Field	**Signatures**
Person's Signature (Optional, if clinically appropriate)	Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.
Date	Next to each signature record the date of the signature.
Parent/Guardian Signature (if appropriate)	
Date	Next to each signature record the date of the signature.
Clinician/Provider – Print Name/Credential	**Legibly print** name and credential(s)of person completing the Comprehensive Assessment.
Date	Next to each signature record the date of the signature.
Supervisor – Print Name/Credential (if needed)	If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.
Date	Next to each signature record the date of the signature.
Clinician/Provider Signature	**Legible signature** of person completing the Comprehensive Assessment.
Date	Next to each signature record the date of the signature.
Supervisor Signature (if needed)	If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Date	Next to each signature record the date of the signature.
Psychiatrist/MD/DO (if required)	This is a requirement for Opiate Treatment Programs.