

SAN FRANCISCO COUNSELOR INFORMATION FORM (SFCIF)

CLIENT INFORMATION

Date of Birth (mm/dd/yyyy): ____/____/____

Client ZIP: _____

Test election (check one):

- Anonymous
- Confidential
- Declined testing

Gender (check one):

- Male
- Female
- Transgender (MTF)
- Transgender (FTM)
- Intersex
- Declined/Don't know

Race/Ethnicity (check all that apply):

- Alaska Native/Native American
- Asian
- Black/African American
- Hispanic/Latino(a)
- Native Hawaiian/Pacific Islander
- White
- Other
- Declined/Don't know

Sexual Orientation (check one):

- Gay/Lesbian/Queer
- Bisexual
- Heterosexual/Straight
- Other
- Declined/Don't know

Health Coverage (check one):

- Healthy SF
- Medi-cal
- Medicare
- Private (Kaiser/Sutter/HMO)
- Other
- None
- Declined/Don't know

Housing Status (check one):

- Permanent (rent/own)
- Temporary (with friend/SRO)
- Homeless/Shelter
- Declined/Don't know

Previous HIV Test:

- Yes
- No
- Don't know
- Declined
- Not asked

Self Reported Result:

- Positive
- Negative
- Indeterminate
- Not asked
- Prelim. Pos./Reactive
- Don't know
- Declined

Date of last test: ____/____

Referrals:

- None
- PEP
- Other
- Additional HIV testing in another location
- Hepatitis vaccination, testing, treatment, or services
- STD testing
- Non-HIV medical care
- Other HIV prevention services

Was a specific risk-reduction plan developed with this client? Yes No

If risk information is blank:

- Client was not asked about risk factors
- Client was asked, but no risk was identified
- Client declined to discuss risk factors

Site Number:

Test Date (mm/dd/yyyy):
____/____/____

PURPLE/YELLOW
LAB STICKER

RED
LAB STICKER

SEXUAL BEHAVIOR HISTORY

In the past 12 months, have you had:

<i>Male partners</i>	<input type="checkbox"/> Yes → <input type="checkbox"/> No	If Yes, please mark all that apply: <input type="checkbox"/> Vaginal sex <input type="checkbox"/> Anal insertive sex <input type="checkbox"/> Anal receptive sex
<i>Female partners</i>	<input type="checkbox"/> Yes → <input type="checkbox"/> No	If Yes, please mark all that apply: <input type="checkbox"/> Vaginal sex <input type="checkbox"/> Anal sex
<i>Transgender partners</i>	<input type="checkbox"/> Yes → <input type="checkbox"/> No	If Yes, please mark all that apply: <input type="checkbox"/> Vaginal sex <input type="checkbox"/> Anal sex

How many people have you had vaginal or anal sex with in the past 12 months?

Have you had any unprotected vaginal or anal sex in the past 12 months? Yes No

Have you had any vaginal or anal sex with someone who has HIV in the past 12 months? Yes No Don't Know

Have you had any unprotected anal sex since your last HIV test? Yes No Not Applicable (no previous HIV test)

SUBSTANCE USE HISTORY

In the past 12 months have you used any of these substances? (Check all that apply or select "I have not used any of these substances")

Alcohol (if checked, do either of the following apply)
 4 or more drinks every day
OR
 6 or more drinks on a typical day when drinking

Crack (rock)
 Poppers (amyl nitrate)
 Powdered cocaine
 Speed (crystal, meth, tina)
 I have not used any of these substances in the past 12 months

Have you injected drugs in the past 12 months?
 Yes No

↳ **If yes, did you share drug injection equipment?**
 Yes No

STD/HEPATITIS HISTORY

Have you been diagnosed with any of the following in the past 12 months? (Check all that apply or select "I have not been diagnosed with any of the above")

Chlamydia Syphilis
 Gonorrhea Declined/Don't Know
 I have not been diagnosed with any of the above in the past 12 months

Have you ever been diagnosed with Hepatitis C?
 Yes
 No
 Declined/Don't know

RAPID TEST #1	RAPID TEST #2	RAPID TEST #3																								
Specimen Type: <input type="checkbox"/> Blood: finger stick <input type="checkbox"/> Blood: venipuncture <input type="checkbox"/> Oral	Specimen Type: <input type="checkbox"/> Blood: finger stick <input type="checkbox"/> Blood: venipuncture <input type="checkbox"/> Oral	Specimen Type: <input type="checkbox"/> Blood: finger stick <input type="checkbox"/> Blood: venipuncture <input type="checkbox"/> Oral																								
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Buff No. _____ Exp. Date ____/____/____																										
Was the rapid test result provided to the client? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: Date of Disclosure ____/____/____ Counselor ID _____ If NO: <input type="checkbox"/> Client declined notification <input type="checkbox"/> Did not return/Could not locate <input type="checkbox"/> Obtained results from other agency	Was the rapid test result provided to the client? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: Date of Disclosure ____/____/____ Counselor ID _____ If NO: <input type="checkbox"/> Client declined notification <input type="checkbox"/> Did not return/Could not locate <input type="checkbox"/> Obtained results from other agency	Was the rapid test result provided to the client? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: Date of Disclosure ____/____/____ Counselor ID _____ If NO: <input type="checkbox"/> Client declined notification <input type="checkbox"/> Did not return/Could not locate <input type="checkbox"/> Obtained results from other agency																								
Test #1 result: <input type="checkbox"/> Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result	Test #2 result: <input type="checkbox"/> Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result	Test #3 result: <input type="checkbox"/> Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result																								
IF REACTIVE: Did client provide a confirmatory sample? (COMPLETE CONFIRMATORY SECTION) <input type="checkbox"/> Yes <input type="checkbox"/> Client declined confirmatory test <input type="checkbox"/> Did not return/Could not locate <input type="checkbox"/> Referred to another agency <input type="checkbox"/> Other																										

CONVENTIONAL/CONFIRMATORY TEST		
(COMPLETE RED LAB SLIP AND SUBMIT TO LAB, ATTACH RED LAB SLIP STICKER TO FRONT OF CIF)		
Conventional/Confirmatory Test result: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result	Specimen Type: <input type="checkbox"/> Blood: venipuncture <input type="checkbox"/> Oral	Were the results provided to the client? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: Date of Disclosure ____/____/____ Counselor ID _____ If NO: Why not? <input type="checkbox"/> Client declined notification <input type="checkbox"/> Did not return/Could not locate <input type="checkbox"/> Obtained results from another agency <input type="checkbox"/> RTA site

If Confirmed HIV Positive (ATTACH RED LAB STICKER TO FRONT OF CIF AND STAPLE LAB RESULT TO CIF):
Did the client receive partner services? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the client referred to HIV prevention services (prevention with positives)? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the client referred to medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If yes, did the client attend the first appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> No <input type="checkbox"/> Client already in care <input type="checkbox"/> Client declined care

HEPATITIS C TESTING (SFDPH Funded Hep C testing ONLY)	RNA TESTING
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Insert Home Access PIN or Lab Sticker Here </div>	Did the client receive an RNA test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If YES, what was the result? <input type="checkbox"/> NAAT positive <input type="checkbox"/> NAAT negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid (ATTACH RED LAB SLIP STICKER TO FRONT OF CIF AND STAPLE LAB RESULT TO CIF IF NAAT POSITIVE)
If a Hepatitis C test was provided, what was the result? (mark one): <input type="checkbox"/> Hep C Positive <input type="checkbox"/> Hep C Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid Did the client return for his or her Hepatitis C test result? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: Date of Disclosure ____/____/____ Counselor ID _____	

NOTES	
FOR INTERNAL USE ONLY: Final Test Result: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result <input type="checkbox"/> NAAT-pos <input type="checkbox"/> FP (rapid test) Final Test Result Disclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	