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: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Declined

Client Race: ☐ Black/African American ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Not Specified ☐ Unknown ☐ Declined

Sex assigned at Birth: ☐ Male ☐ Female ☐ Declined

Current Gender Identity: ☐ Male ☐ Transgender – Male ☐ Transgender – Not Specified ☐ Female ☐ Transgender – Female ☐ Another Gender ☐ Declined

Previously Tested for HIV? ☐ Yes ☐ No ☐ Unknown

Section 3 **FINAL TEST INFORMATION**

HIV Test Election ☐ Confidential ☐ Test not done

Was result provided to client? ☐Yes ☐No

Point of Care (POC) Rapid Test Result
☐ Negative
☐ Discordant
☐ Preliminary Positive

Section 4 **NEGATIVE TEST RESULT**

Is client at risk for HIV infection? ☐ No ☐ Yes ☐ Unknown

Was client screened for PrEP eligibility? ☐ No ☐ Yes

Is client eligible for PrEP referral? ☐ No ☐ Yes, by CDC criteria ☐ Yes, by local criteria or protocol

Was client referred to a PrEP provider? ☐ No ☐ Yes

Was the client provided with services to assist with the linkage to a PrEP Provider? ☐ No ☐ Yes

Section 5 **POSITIVE TEST RESULT**

Has client ever had a positive HIV test? ☐ No ☐ Yes ☐ Don't know

If yes, date of first positive results: ____/____/____

Did client attend post-test medical care appointment?
☐ No ☐ Yes, client self-reported
☐ Don't know ☐ Yes, confirmed

If yes, date attended: ____/____/____

Was client provided with individualized behavioral risk-reduction counseling? ☐ No ☐ Yes

Was client's contact information provided to the health department for Partner Services? ☐ No ☐ Yes

What was the client's most severe housing status in the last 12 months?
☐ Literally homeless ☐ Stably housed ☐ Unstably housed and at-risk of losing housing
☐ Not asked ☐ Declined to answer ☐ Don't know

*(Females Only) Is the client pregnant? ☐ No ☐ Yes ☐ Declined to Answer ☐ Unknown	*(If pregnant) Is the client receiving prenatal care? ☐ No ☐ Yes ☐ Declined to Answer ☐ Unknown
*(If pregnant) Was the client screened for the need of perinatal HIV service coordination? ☐ No ☐ Yes	*(If pregnant) Does the client need perinatal HIV service coordination? ☐ No ☐ Yes
*(If pregnant) Was the client referred for perinatal service coordination? ☐ No ☐ Yes	

Section 6 **ADDITIONAL TESTS**

Was the client tested for co-infections? ☐ No (skip to Section 7) ☐ Yes (see below)

Tested for Syphilis? ☐ No ☐ Yes Syphilis test result (if tested): ☐ Negative ☐ Newly identified infection ☐ Not Known	Tested for Gonorrhea? ☐ No ☐ Yes Gonorrhea test result (if tested): ☐ Negative ☐ Positive ☐ Not Known
Tested for Chlamydia? ☐ No ☐ Yes Chlamydia test result (if tested): ☐ Negative ☐ Positive ☐ Not Known	Tested for Hepatitis C? ☐ No ☐ Yes Hepatitis C test result (if tested): ☐ Negative ☐ Positive ☐ Not Known

Show Supplemental HIV Test – Choose NO

Section 7 **PrEP Awareness / Use / Population**

Has the client **ever heard of PrEP** (Pre-Exposure Prophylaxis)?	☐ No ☐ Yes
Is the client currently **taking daily PrEP** medication?	☐ No ☐ Yes
Has the client **used PrEP** any time in the last 12 months?	☐ No ☐ Yes
In the past 5 years, has the client had **sex with a male**?	☐ No ☐ Yes
In the past 5 years, has the client had **sex with a female**?	☐ No ☐Y es
In the past 5 years, has the client had **sex with a transgender person**?	☐ No ☐ Yes
In the past 5 years, has the client **injected drugs or substances**?	☐ No ☐ Yes

Section 8 **Essential Support Services** **(complete for all clients except as indicated)** [1]

*First (3) for HIV positive cases only	Screened for need	Need determined	Provided or referred
Navigation for HIV related medical care*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Linkage to HIV medical care*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medication adherence support*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Health benefits navigation & enrollment	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Evidence based risk reduction	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Behavioral Health	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Social Services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Notes:

[1] Dec 2023