Client Name _____ ID _____

COMPREHENSIVE ASSESSMENT SUMMARY COVERSHEET

Include the following:

a) Demographics, risk factors, and referral source.

b) Living situation and communication ability (note restrictions).

c) Substance use (past and current).

d) Suicide history and any significant psychiatric information.

e) NEEDS: To be addressed <u>currently</u> and <u>deferred</u> (prioritize).

CM Signature _____ Date Completed _____

Supervisory Signature _____ Date _____

Assessment Cover 2005

COMPREHENSIVE ASSESSMENT

Client Name: _____ **ID#**: _____ **DOB:** _____ **Age:** ____

Would you like to be referred to by any other name? _____ **Assessment Start Date:** _____

MEDICAL

All medical information must be verified and documented. This includes verification of HIV status, most recent lab results, and TB status. Examples of verification include, but are not limited to, lab reports, HASA enrollment, letter from a physician or medical provider, or medical personnel, i.e. social worker, etc.

HIV/AIDS STATUS (Primary Diagnosis):

What is current HIV status? (From medical verification, where possible):

____ HIV+/Asymptomatic ____ HIV+/Symptomatic ____ AIDS

Transmission Route _____

____ Pending Test/Unknown-at Risk If unknown, what are the risk factors? _____

Verification in chart? ____ Yes ____ No Method of verification: _____

Does client want to be tested for antibodies to HIV? ____ Yes (discuss pre-test counseling/referral) ____ No

CD4 Count _____ Date _____ Viral Load _____ Date _____

Document attempts to obtain:

_____

_____

Does client understand meaning of VL & T-Count and how to read lab results? (Explain):

_____

_____

Does client need referral for further HIV information/education? ____ Yes ____ No

CURRENT MEDICAL CARE

Is client receiving medical care? ___ Yes ___ No
Is client enrolled in a SNP? ___ Yes ___ No

If yes, name: _____ CM: _____

LIST PHYSICIANS, HOSPITALS, AND HEALTH CLINICS WHERE CLIENT RECEIVES HIV HEALTH CARE TREATMENT AND/OR OTHER HEALTH CARE SERVICES:

Type of Provider	Name	Address/Phone	Contact	Last Appointment Date
Primary:				
Gyn (if different):				
Other (ex: Urologist):				

How often does client see PCP? _____

Does client schedule own appointments? ___ Yes ___ No

Identify any barriers that prevent client from keeping appointments:

How does client assess/perceive level of HIV care received from PCP?

Last hospitalization: _____ Place: _____

Nature of most recent hospitalization: _____

In client's own words, how would she/he describe her/his health? (Has her/his health recently improved or declined; has there been a significant change in T-cell/VL; are there concerns around her/his health; does she/he think the medication regimen is working, etc.)

HIV Related Medical Problems: Indicate opportunistic infections reported by client or physician. The following lists common AIDS related illnesses. Check if yes and indicate the last date of illness/infection. This is **not** a comprehensive list. Please list any other HIV related medical problems under "Other HIV Related Symptoms" and include the last date of illness/infection.

	Yes	Date		Yes	Date
Candidiasis of bronchi, trachea, or lungs			Kaposi's Sarcoma		
Candidiasis, esophageal			Lymphoma, Burkett's		
Cervical cancer, invasive			Lymphoma, immunoblastic		
Oral Thrush			Lymphoma, brain		
Cryptococcus, extra pulmonary			Mycobacterium Avium Complex		
Cryptosporidiosis, intestinal			Mycobacterium Tuberculosis		
Cytomegalovirus Disease			Pneumocystis pneumonia (PCP)		
Cytomegalovirus Retinitis			Pneumonia, recurrent		
Encephalopathy, HIV-related			Multifocal leukoencephalopathy		
Herpes Simplex, recurrent			Recurrent Vaginal Candidiasis		
Histoplasmosis			Toxoplasmosis, brain		
Peripheral Neuropathy			Wasting Syndrome		
Avascular (i.e. bone) necrosis			Lipodystrophy		

OTHER HIV RELATED SYMPTOMS:

MEDICATIONS

The AIDS Institute updates the Medication List form on a quarterly basis for use with assessments and reassessments. Using the most recent copy of the AI Medication List form - please print a blank form, complete and replace this page with client's current medications.

ALLERGIES/ASTHMA - List known allergies:

_____

_____

_____

_____ No known allergies

Does client suffer from Asthma?	_____ Yes	_____ No
If Yes, is client being treated via Meds/Inhaler/Oxygen?	_____ Yes	_____ No
Does the client smoke?	_____ Yes	_____ No
Does the client indicate willingness to stop smoking?	_____ Yes	_____ No
Does client want/need referral to Stop Smoking Program?	_____ Yes	_____ No

Other conditions (ex. Diabetes, Hypertension, Heart Disease, etc.):

_____

ADHERENCE:

How does she/he feel about taking the prescribed medication? _____

What is important to her/him about her/his medication? _____

Comments (discuss side effects, difficulties following regimen, and barriers to taking medications *as prescribed*):

_____

_____

_____

Does she/he understand the consequences of missing doses?	_____ Yes	_____ No
Does client feel she/he knows enough about the medication she/he is taking?	_____ Yes	_____ No
How does client usually take meds (check all that apply)?	_____	
Always takes all pills on time according to the directions.	_____	
Sometimes misses or forgets to take pills.	_____	
Not too careful about taking pills.	_____	
Not sure.	_____	

Explain the client's level of understanding regarding the need to eat/not eat with certain medications:

_____

_____

From what pharmacy does the client access medications? _____

ADHERENCE CONCERNS/INSIGHTS: Summarize your discussion about "taking medications" and the client's understanding of the consequences of missing a dose. **NOTE: If the participant has serious barriers to understanding adherence, summarize the barriers below. Add to Service Plan, notify primary care provider, and set up an appointment with an adherence specialist/treatment educator/supervisor.**

_____

_____

CLINICAL TRIALS

Does the client know what a Clinical Trial is?	_____ Yes	_____ No
Has the client ever participated in Clinical Trials?	_____ Yes	_____ No
Is the client currently participating in a trial?	_____ Yes	_____ No
Is the client interested in discussing options?	_____ Yes	_____ No

(Any information related to Clinical Trials should be discussed during the next medical case conference)

WOMEN'S HEALTH ISSUES

Date of last OB/GYN exam: _____

Was PAP test done within the last six months? _____ Yes _____ No

Date of last Pap: _____ Results: _____

Is client pregnant? _____ Yes _____ No

LMP (last menstrual cycle): _____

(Discuss if time sequence seems unusually long): _____

_____

_____

If over age 40, approximate last date of mammogram: _____ Results _____

Sexually Transmitted Disease (STD) History:

STD	Date of Diagnosis	Treatment		Comments (current symptoms, on meds)
		Yes	No	
		Yes	No	
		Yes	No	

What are client's thoughts on family planning? _____

Is family planning in place? _____

Comments: _____

_____

<u>If client is pregnant, complete the following</u>:

Estimated # of weeks _____

Is client receiving prenatal care? _____ Yes _____ No

Is client on Anti-Retroviral Therapy? _____ Yes _____ No

Has client informed HASA/PA worker of pregnancy (budget revisions)? _____ Yes _____ No

Other women's health issues/comments (include client's need for regular mammograms if over 40, menopause if applicable, description of client's hygiene, etc.):

_____

_____

_____

_____

_____

_____

Is HIV verification in chart? _____ Method of verification _____

MEN'S HEALTH ISSUES

Has client undergone a Prostate Exam? _____ Yes _____ No Date: _____

Has client undergone a Testicular exam? _____ Yes _____ No Date: _____

Sexually Transmitted Disease (STD) History:

STD	Date of Diagnosis	Treatment	Comments (current symptoms, on meds)
		Yes No	
		Yes No	
		Yes No	

What are client's thoughts on family planning? _____

Is family planning in place? _____

Comments: _____

OTHER MEN'S HEALTH ISSUES/COMMENTS

(Include description of client's hygiene; inquire if client is taking erectile dysfunction medication, i.e., Viagra, Cialis or Levitra):

TRANSGENDER HEALTH ISSUES

How does client identify? _____

HRT (hormone replacement therapy)? ____ Yes ____ No If yes, date started? _____

How does client access HRT? _____

Name of physician if prescribed by other than regular PCP: _____

Is regular PCP aware of other physician's treatment? _____ Yes _____ No

STD	Date of Diagnosis	Treatment	Comments (current symptoms, on meds)
		Yes No	
		Yes No	
		Yes No	

Other transgender health issues/comments (include client's need for referrals to transgender specific health care or Gender Identity Project, etc., description of client's hygiene, etc.):

GENERAL HEALTH ISSUES

Client's TB status is: ____ Positive ____ Negative ____ Anergic ____ Not Known

Client on TB medications? ____ Yes ____ No PPD Date: _____ Chest X-Ray Date: _____

Is client currently on Directly Observed Therapy (DOT)? ____ Yes ____ No

If yes, program is: _____ If no, need for DOT referral? ____ Yes ____ No

Is client experiencing any barriers to taking medications on schedule? ____ Yes ____ No
If yes, explain:

Has client completed TB treatment in the past? ____ Yes ____ No Date completed _____

Follow-up needed for family/collaterals? Describe. _____

HEPATITIS

Has client ever been treated for Hepatitis? ____ Yes ____ No Screening Date: _____

Type of Hepatitis Test: A ____ B ____ C ____ Results: _____

Is client currently being treated for Hepatitis? ____ Yes ____ No

Type of Treatment: _____

Has client been vaccinated? A ____ B ____ No ____

Has client been provided information on Hepatitis and HIV (Hepatitis/HIV pamphlet)? ____ Yes ____ No

If no, explain: _____

All medical information discussed thus far should be verified, documented, and discussed with the medical provider either via the social worker, nurse practitioner, or if necessary, the physician.

DENTAL CARE

Does client receive ongoing dental care? _____ Yes _____ No Date of last visit: _____

Provider: _____ Address: _____

_____ _____

_____ Phone: _____

Comments on dental problems or barriers to services (i.e. lack of access to providers, fear of dentists, etc.):

_____

_____

_____

VISION CARE

Does client receive ongoing vision care? _____ Yes _____ No Date of last visit: _____

Provider: _____ Address: _____

_____ _____

_____ Phone: _____

Comments on vision problems or barriers to services (i.e. lack of access to providers, fear of exam, etc.):

_____

_____

_____

NOTE: *If CD4<200, explain to client possible effects of HIV on vision (i.e. CMV retinitis) and add to service plan objective of completing eye exam EVERY SIX MONTHS.*

WELLNESS

NUTRITION

Ask client to describe appetite:

_____

_____

_____

How many meals during the day? _____ Type of food (fast food, cooks at home)? _____

Is client taking food supplements? _____ Yes _____ No **If yes, please add to medication section.**

Has client experienced a significant weight change recently? ___ Yes ___ No Explain any change:

_____

_____

_____

Does client need a referral to a nutritionist? _____ Yes _____ No

COMPLEMENTARY/ALTERNATIVE THERAPIES

Is the client accessing complementary/alternative therapy (i.e. massage, acupuncture, herbal remedies)? ____ Yes ____ No

Explain:

Is client interested in obtaining information on complementary/alternative therapies? ____ Yes ____ No

Comments:

(If client expresses interest, discuss interest or use during next medical case conference)

HOME CARE

Is client currently receiving home care? ____ Yes ____ No (When no, SKIP to bolded area in HOME CARE section.)

Home Care Agency: _____ Phone #: _____

Name of Nurse/Home Health Aide: _____

How does client feel about current home care? _____

Indicate which services are being utilized:

_____ Nursing _____ Visits per week _____ Occupational therapy _____ Days per week

_____ Physical Therapy _____ Days per week _____ Other _____

Is client in need of an evaluation for home care services? ____ Yes ____ No

Comments: _____

TRANSPORTATION

Does client have regular access to transportation? ____ Yes ____ No Inconsistent ____

What is client's usual method of transportation? _____

Describe client's transportation needs: _____

EMPLOYMENT/EDUCATION

EMPLOYMENT STATUS:

Employed ___ Job Training Program ___ Stipend position ___ Unemployed ___ Disabled ___

Comments (employer information, occupation, hours per week, etc.): _____

Comments (name of job training program and counselor, phone #): _____

Comments (previous job history): _____

NOTE: When client states she/he works "off the books," please advise the client of the need to alert the DSS/HASA/HRA worker of the additional income; also remind the client of the need to report any income to appropriate government agencies (i.e. IRS).

EDUCATION

Indicate highest grade/degree of education reached by client: _____

What language(s) does client speak fluently? _____

Can client:
Read English? ___ Yes ___ No Read (other)? ___ Yes ___ No Name of language(s): _____

Write in English? ___ Yes ___ No Write (other)? ___ Yes ___ No _____

Comment on client's interest in educational opportunities (GED) and/or job training:

_____

FINANCIAL RESOURCES/ENTITLEMENTS

Total monthly income: _____ Total Monthly Expenses: _____ Medicaid #: _____

Source	Amount	Source	Amount
Wages		Alimony	
Social Security		Child Support	
Public Assistance		Unemployment	
SSI/SSD		Veteran's Benefits	
Medicaid/Medicare		Enhanced Rent	
HASA		Energy Assistance	
ADAP		Food Stamps	
WIC		Other	

Does client have outstanding debts? _____ Yes _____ No
Explain:

Does client have a representative payee? _____ Yes _____ No Who? _____

Is client/household income sufficient to meet basic needs? _____ Yes _____ No

If no, explain situation:

Evaluate client's ability to manage his/her own finances:

Does the client need a fair hearing/appeal process for any denials of entitlements? _____ Yes _____ No

Explain situation:

Medicaid re-certification date: _____ **Any spend-down amount?** _____

Is client in need of a referral for additional food sources (i.e. Momentum Food Project, God's Love We Deliver, local soup kitchens, etc.)? _____ Yes _____ No (If yes, add to Service Plan)

Name of HASA/PA Worker: _____ Phone #: _____
Comments (include any difficulties with worker):

HOUSING
A HOME VISIT MUST BE COMPLETED AS PART OF THE ASSESSMENT PROCESS

Date of home visit: _____

If home visit not conducted, why? _____

Current housing situation (rent apartment, scatter-site, congregate, nursing home, shelter, SRO, friends): _____

Is it stable? ___ Yes ___ No

Has client been assisted with housing before? ___ Yes ___ No If yes, by whom? _____

How many times has client moved from apartments in the past 5 years? _____
Reasons:

Can client pay her/his portion of the rent?	___ Yes	___ No	Does client have a checking account?	___ Yes	___ No
Can client write out a check/money order?	___ Yes	___ No	Does client have problems paying the rent?	___ Yes	___ No
Has client been in rent arrears?	___ Yes	___ No	Is client legally assisted with rent issues?	___ Yes	___ No
Has client ever lived alone?	___ Yes	___ No	Does client feel comfortable living alone?	___ Yes	___ No
Does client plan to live alone?	___ Yes	___ No	If no, with whom?		

Does client think she/he would benefit from living in supportive living? ___ Yes ___ No

Does client have concerns living in housing provided by an AIDS organization? ___ Yes ___ No

Comments (current housing situation, barriers to housing placement, financial management, and possible referrals):

PARENTING AND FAMILY AND SOCIAL SUPPORTS

Does client have any minor children under the age of 21? ___ Yes ___ No (If no, skip.)
This needs to be completed regardless of child's HIV status or living arrangement. For minor children living outside of the home, an assessment needs to be completed indicating what needs the child may have and who the primary caregiver is that is meeting these needs (address any deficits in meeting child's needs).
List all minor children considered to be part of the household:

Name	Sex	Age	HIV Status	Living in home? (Yes or No)	Living with other? (specify)	Aware of client's HIV status? (Yes or No)	Aware of own HIV status? (Yes or No)

Describe current relationship with children listed above:

If client has minor children living outside of the home, does client wish to have increased contact and/or custody of children? ____ Yes ____ No Comments:

Is there a need for any of the following:
Parenting skills training? ____ Yes ____ No Specify: _____

Respite care? ____ Yes ____ No Specify: _____

Child Care? ____ Yes ____ No Specify: _____

Is there suspected/confirmed child abuse/neglect? ____ Yes ____ No Explain: _____

Is CPS/ACS involved? ____ Yes ____ No Explain: _____

NOTE: It is our responsibility as mandated providers to report suspicion of child abuse and/or neglect.

FAMILY SUPPORT [Not minor children]

Client's current spouse/partner: _____ Spouse/Partner's HIV status: _____

Is spouse/partner aware of client's HIV status? ___ Yes ___ No ___ Not sure

Is client in need of a referral to partner notification services? ____ Yes ____ No

Who does client identify other family/collateral support or significant others? (Include parents, siblings, significant others who ARE supportive.)

Name	Relation-ship	Age	HIV Status	Address	Phone #	Aware of client's HIV status? (yes or no)

Describe family relationship/patterns of communication, roles, and types of support:
[i.e., Who would you go to if you were depressed, needed money, needed someone to talk to, etc.?]

Are the client's parents living? Mother: ___ Yes ___ No Father: ___ Yes ___ No

If yes, describe your relationship:

How would you describe your childhood?

DOMESTIC VIOLENCE

DOMESTIC VIOLENCE ASSESSMENT

Does the client report feeling unsafe in her/his current living arrangement? _____ Yes ___ No

If yes, describe:

How is the situation today?

Does the client report feeling afraid that she/he will resort to physical force when interacting with a significant other OR her/his children? _____ Yes _____ No Explain any "Yes" answers:

Does the client believe that domestic violence is an issue at this time? ___ Yes ___ No If yes, explain:

Is client currently in a program that is addressing this issue? ___ Yes ___ No If yes, explain:

If client does not believe that violence is an issue, does **worker** have any reason to believe that this is an issue? ___ Yes ___ No If yes, explain:

PARTNER/SPOUSAL NOTIFICATION

Are there past/present partners (sexual or needle sharing) with whom the client has **not** discussed her/his HIV status with? _____ Yes _____ No (if no, skip this section)

Discuss importance/benefits of partner notification with client!

Options Discussed:
- ___ Self Notification
- ___ Joint Notification
- ___ Client declines to notify partner
- _____ Notification with assistance by PNAP/CNAP
- _____ Notification by Health and Human Service Provider

What issues need to be resolved to encourage partner/spousal notification?

SUBSTANCE ABUSE AND MENTAL HEALTH

SUBSTANCE ABUSE HISTORY

Does client have a history of drug/alcohol use? ___ Yes ___ No If no, then leave blank and skip to **Mental Health History.**

Drugs used currently or in the past:

Type	Frequency of Use	Route of Administration	Amount	Date of Last Use
Nicotine				
Alcohol				
Marijuana				
Cocaine				
Crack				
Heroin				
Hallucinogens				
Crystal Meth				
Other				

TREATMENT HISTORY

Has client ever sought treatment for alcohol/drug use? ___ Yes ___ No. If no, leave blank and skip to Mental Health History.

Past Dates	Modality	Place	Completed? (yes or no)

Note past barriers to or reasons why program was not completed:

_____

_____

_____

CURRENT TREATMENT

Is client currently enrolled in substance abuse treatment? ___ Yes ___ No If yes, length of time: _____

Current and post modalities	Date	Comments
Detox (7 day or 28 day)		
Recovery Readiness		
Harm reduction/Needle exchange		
Inpatient substance use program		
Outpatient substance use program		
Methadone Maintenance (# of mg)		
Outpatient alcohol program		
Inpatient alcohol program		
AA/NA or other self-help group		
Stop Smoking Program		

Name and address of program attending: _____

_____

_____

Worker name: _____
Worker phone #: _____
Frequency of visits: _____
Comment on client's ability to keep appointments: _____

Regardless of treatment history, does the client consider her/himself in recovery? _____ Yes _____ No

What has helped client remain clean?

_____

_____

_____

_____

Does client have an awareness of what her/his relapse "triggers" are? Discuss:

_____

_____

_____

_____

If client is ACTIVELY using a substance:

Are harm reduction methods being used? ___ Yes _____ No (Refer to HIV Prevention) Explain:

_____

_____

_____

Does client indicate or state a willingness to stop? ___ Yes _____ No Explain: _____

_____

_____

_____

What attempts have been made to stop using?

_____

_____

_____

Evaluate client's willingness to stop using alcohol/drugs:

_____

_____

_____

_____

Is the client interested in addressing substance use? _____ Yes _____ No
Is referral for substance abuse treatment warranted? _____ Yes _____ No

MENTAL HEALTH HISTORY

Has client ever received psychiatric or mental health treatment? ___ Yes ___ No

If yes, please indicate diagnosis as reported by client: _____

If yes, please indicate symptoms as reported by client: _____

Comments (If yes above, please conference with mental health providers):

_____

_____

Current and Past Modalities

Check Modality	Date	Comments
_____ Support group	_____	
_____ Individual counseling/therapy	_____	_____
_____ Family counseling	_____	_____
_____ Outpatient psych (Private PhD/MD)	_____	_____
_____ Inpatient psychiatric care	_____	_____
_____ Other mental health care	_____	_____

Has client ever been hospitalized for a psychiatric condition? ___ Yes ___ No

Dates:	Where:	For:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Clinician (current/most recent): _____ **Frequency of Visits:** _____

Address: _____

_____

Phone #: _____

Does client keep appointments? ___ Yes ___ No Inconsistent because? _____

Currently or ever prescribed medication for a psychiatric/emotional condition? Yes No

Prescribed Medication	Purpose	Dosage/Frequency	Last Use (approximately if in the past year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Feelings about prescribed medication: _____

Does client report adherence to this medication regimen? ____ Yes ____ No ____ Inconsistent

Barriers to taking medication as prescribed: _____

Has client ever attempted suicide? ___ Yes ___ No Discuss (i.e. approximate dates, method, and precipitating events):

_____

_____

Has client ever had thoughts of hurting her/himself? ____ Yes* ____ No Explain:

Does client have current suicidal ideation? ____ Yes* ____ No
If yes, does client have a plan? ____ Yes* ____ No

***If yes, what is the plan? Discuss with supervisor.**

Has client ever had feelings of depression? ____ Yes ____ No Explain:

Significant losses/traumatic events? ____ Yes ____ No Explain:

Is client interested in counseling/therapy? ____ Yes ____ No Explain:

In YOUR opinion:

Is a mental health evaluation warranted based on the above questions? ___ Yes ___ No Explain:

Is there a need for or interest in counseling or support groups? Yes No Explain:

_____ Individual _____ Family/Collaterals _____ Other:

Self Image [Ask the following questions and quote client]:
What do you see as your strengths?

What would you like to change about yourself?

What helps you cope with feelings of loss, stress, and depression?

SOCIAL ACTIVITIES

What do you do in your spare time? _____

What are your interests? Do you participate in social activities, sports, clubs, or organizations?

_____

_____

Are your friends and family members a support for you? ___ Yes ___ No

Would you like to make more friends? ___ Yes ___ No

Who do you consider to be a part of your social circle? _____

_____

Is your religion/faith/spirituality important to you? ___ Yes ___ No
Is your faith a support for you? ___ Yes ___ No
Is there a particular group or congregation you are involved in? ___ Yes ___ No

ACTIVITIES OF DAILY LIVING

Review/Assess Ability to perform the following: 0=Self 1=Some Assistance 2=Total Assistance (From whom?)

ADL	0 Self	1 Some assistance	2 Total assistance	From whom?
Eating				
Ambulating				
Transferring				
Grooming				
Dressing				
Bathing				
Toileting				
Homemaking				
Grocery Shopping				
Financial Management				
Travel/Transportation				
Using telephone				
Laundry				
Decision Making				

Recommended Care Environment:
Alone _____ With home care ___ Family ___ Supportive Housing ___ Nursing Home ___ Hospice ___
Other _____ Explain: _____

Comments/Needs: (Taking into consideration the participant's physical abilities and social assessment, note NEEDS-DESIRES)

_____

_____

_____

_____

_____

LEGAL

Has client ever been incarcerated? ___ Yes ___ No

If yes:
Where? _____ When? _____ Nature of Incarceration: _____

Is client currently on probation or parole? ___ Yes ___ No

If yes, until when? _____ Name of Parole/Probation Officer: _____
Phone # of Parole/Probation Officer: _____

Is client currently serving any type of sentence (i.e. community service hours, etc.)? ___ Yes ___ No
Explain:

Does client have any outstanding warrants/summonses/cases pending? ___ Yes ___ No
Explain:

Is client in need of assistance with any of the following?

	Yes	No	In-Place	Comments
Health Care Proxy				
Living Will				
Power of Attorney				
Immigration				
Permanency Planning				
Standby Guardianship				

HIV PREVENTION WITH POSITIVES

SAFER SEX/DRUG USE:

Describe current risk behaviors:

The following risk and harm reduction information was discussed on (date): _____

Does the client currently have a sex partner or partners? ____ Yes ____ No

Are their partner(s) aware of their own HIV status? ____ Yes ____ No

Do they need help getting tested? ____ Yes ____ No

How is the client doing practicing safer sex?

What works for the client and what doesn't when it comes to safer sex (e.g. condom use, dental dam, etc.)?

Does being high or drinking get in the way of practicing safer sex? ____ Yes ____ No

Summarize discussion, including safer sex information provided:

Would the client like to work with a trained counselor/educator person to help improve safer sex practices? ___ Yes ___ No

IF THE CLIENT IS ALSO INJECTING DRUGS:

What works for the client and what doesn't when it comes to using a new or clean syringe and works with every shot?

Does the client ever find her/himself in a situation where they are sharing syringes or works? ___ Yes ___ No

Does the client know she/he can get clean syringes, help practicing safer drug use through a syringe exchange program, or purchase syringes at an ESAP pharmacy/hospital? ___ Yes ___ No

Summarize your discussion with the client about drug-related harm reduction methods:

Do they need a referral? ___ Yes ___ No

SUBSTANCE USE BEHAVIOR

Drug Use: ____ Yes ____ No Comments: _____

Needle Sharing: ____ Yes ____ No _____

Use of Bleach: ____ Yes ____ No _____

UNIVERSAL PRECAUTIONS

Does the client understand how to protect household members from exposure to HIV? ___ Yes ___ No
Briefly describe their understanding:

Does the client require referral for further information? ___ Yes ___ No

Comments:

OTHER AGENCIES SERVING THE CLIENT AND FAMILY/COLLATERALS:

Name	Service	Agency Contact	Phone Number

Please Note: This ASSESSMENT is not complete without the cover sheet.

All signatures are to be entered on the coversheet.