

Prevention Case Management

Client Information

Agency Name:
Program Model Name:
Intervention Name:

Demographic Information		
Date Collected:	Date of Birth:	State/Territory of Residence:
Ethnicity: <i>(Choose only one)</i> <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race: <i>(Choose all that apply)</i> <input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	
Assigned Sex at Birth: <i>(Choose only one)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Gender: <i>(Choose only one)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender – MTF <input type="checkbox"/> Transgender – FTM <input type="checkbox"/>	
Sexual Orientation:	<input type="checkbox"/>	

Client Unique ID: _____

Prevention Case Management

Client Information

Risk Profile

Date Collected:

Has the client been incarcerated in the past 90 days? (<i>Choose only one</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Not asked
	<input type="checkbox"/> Yes	<input type="checkbox"/> Refused to answer
Has the client engaged in sexual intercourse as their profession, occupation or principal activity that they do to earn money in the last 90 days? (<i>Choose only one</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Not asked
	<input type="checkbox"/> Yes	<input type="checkbox"/> Refused to answer
If the client's current sex is female, is the client currently pregnant? (<i>Choose only one</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Refused to answer
	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Not asked	
If the client is pregnant, is the client receiving prenatal care? (<i>Choose only one</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Not asked
	<input type="checkbox"/> Yes	<input type="checkbox"/> Refused to answer
Has the client been diagnosed with treatable/curable STD in the last 90 days? (<i>Choose only one</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Not asked
	<input type="checkbox"/> Yes-self report	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes-lab confirmed	
What is the client's housing status? (<i>Choose all that apply</i>)	<input type="checkbox"/> Permanent housing	<input type="checkbox"/> Refused to answer
	<input type="checkbox"/> Non-permanent housing	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> Institution	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Not asked	

Client Unique ID: _____

Prevention Case Management

Client Information

Risk Profile		
Does the client report having had a prior HIV test? <i>(Choose only one)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not asked	<input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
What is the client's self-reported HIV serostatus at this time? <i>(Choose only one)</i>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not asked	<input type="checkbox"/> Refuse to answer <input type="checkbox"/> Don't know
If self-reported HIV negative, date of last HIV negative test:		
If self-reported HIV positive, date of the first positive HIV test:		
If self-reported HIV positive, is the client currently receiving medical care/treatment? <i>(Choose only one)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not asked	<input type="checkbox"/> Refused to answer <input type="checkbox"/> Don't know
Answer the following if the client's HIV status has been confirmed through documentation (lab results)		
Confirmed HIV Test Result: <i>(Choose only one)</i>	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> NAT-positive <input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No result
HIV Test Date:		
Confirmed Documentation Source: <i>(Choose only one)</i>	<input type="checkbox"/> Within Agency <input type="checkbox"/> External test result-Agency provided	<input type="checkbox"/> External test result-Client provided
Confirmation Date:		

Client Unique ID: _____

Prevention Case Management

Client Information

Risk Profile		
Client Risk Factors within the last 90 days: <i>(Choose all that apply)</i>	<input type="checkbox"/> Injection drug use <input type="checkbox"/> Sex with transgender <input type="checkbox"/> Sex with female <input type="checkbox"/> Sex with male	<input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other (specify) _____
Additional Client Risk Factors within the last 90 days: <i>(Choose all that apply)</i>	<input type="checkbox"/> No additional risk information specified <input type="checkbox"/> Exchange sex for drugs/money/or something they needed <input type="checkbox"/> While high on drugs <input type="checkbox"/> With person who is an IDU <input type="checkbox"/> With person who is HIV positive <input type="checkbox"/> With person of unknown HIV status	<input type="checkbox"/> With person who exchanges sex for drugs/money <input type="checkbox"/> With person who is a known MSM <input type="checkbox"/> With anonymous partner <input type="checkbox"/> With person who has hemophilia or transfusion/transplant recipient <input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer

Client Unique ID: _____

Prevention Case Management

Client Information

Behavioral Characteristics			
Date of Completion:	<input type="checkbox"/> Intake	<input type="checkbox"/> Completion of Intervention	
Behavioral Recall Period:	<input type="checkbox"/> 15 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 90 days
Use the recall period to answer the following questions for the client			
Number of sex partners:			
Number of sex events:			
Number of sex partners with serodiscordant or HIV status unknown:			
Number of HIV status unknown sex partners that were Anonymous:			
Number of unprotected sex events with a serodiscordant or HIV status unknown partner :			
Total:	Male:	Female:	Transgender:
Number of unprotected sex events with Injection Drug User:			
Number of unprotected sex events with partner who exchanged sex for drugs or money:			
Number of unprotected sex events while high or buzzed on non-injection drugs:			
What drugs? <i>(Choose all that apply)</i>	<input type="checkbox"/> Amphetamine, meth, speed, crystal, crank, etc. <input type="checkbox"/> Crack <input type="checkbox"/> Cocaine <input type="checkbox"/> Downers <input type="checkbox"/> Pain killers <input type="checkbox"/> Hallucinogens (LSD) <input type="checkbox"/> Ecstasy	<input type="checkbox"/> Club drugs (GHB, ketamine) <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana <input type="checkbox"/> Poppers <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other (specify) <input type="checkbox"/> Don't know	
Number of needle sharing events:			
Number of Injection Drug Events with a serodiscordant or HIV status unknown partner:			

Client Unique ID: _____

Prevention Case Management

Client Information

Intervention Characteristics			
Intervention Name/ID:		Site ID:	
Intended Number of Sessions:	Session Number:	Worker ID:	
Session Date:	Duration of Session: (Hours or Minutes):		
Recruitment Source: <i>(Choose only one)</i> <input type="checkbox"/> Agency <input type="checkbox"/> Partner <input type="checkbox"/> HC/PI <input type="checkbox"/> Friend / Family member <input type="checkbox"/> Self <input type="checkbox"/> Other (specify) _____	If Recruitment Source is Agency, indicate the type of service that the agency was providing when the referral was made: <i>(Choose only one)</i> <input type="checkbox"/> Counseling and Testing <input type="checkbox"/> Outreach <input type="checkbox"/> HC/PI <input type="checkbox"/> HE/RR <input type="checkbox"/> PCRS <input type="checkbox"/> Intake/screening <input type="checkbox"/> PCM <input type="checkbox"/> Other (specify) _____		
If Agency Recruitment Source, indicate the setting that best describes from where or what place the referral was given: <i>(Choose only one)</i>			
<u>Inpatient</u> <input type="checkbox"/> Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Drug/Alcohol Treatment <input type="checkbox"/> Other (specify) _____ <u>Other</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Blood Bank, Plasma Center <input type="checkbox"/> HIV Counseling & Testing Site <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Facility Other	<u>Outpatient</u> <input type="checkbox"/> Facility <input type="checkbox"/> Private Medical Practice <input type="checkbox"/> HIV Specialty Clinic <input type="checkbox"/> Prenatal/OBGYN Clinic <input type="checkbox"/> TB Clinic <input type="checkbox"/> Drug/Alcohol Treatment Clinic <input type="checkbox"/> Family Planning <input type="checkbox"/> Community Mental Health <input type="checkbox"/> Community Health Clinic <input type="checkbox"/> School/University Clinic	<u>Outpatient</u> <input type="checkbox"/> Health Department/Public Health Clinic <input type="checkbox"/> Health Department/Public Health Clinic-HIV <input type="checkbox"/> Health Department/Public Health Clinic-STD <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<u>Community Setting</u> <input type="checkbox"/> AIDS Service Organization-non-clinical <input type="checkbox"/> School/Education facility <input type="checkbox"/> Church/Mosque/Synagogue/Temple <input type="checkbox"/> Shelter/Transitional housing <input type="checkbox"/> Commercial <input type="checkbox"/> Residential <input type="checkbox"/> Bar/Club/Adult entertainment <input type="checkbox"/> Public area <input type="checkbox"/> Workplace <input type="checkbox"/> Community Center <input type="checkbox"/> Other

Client Unique ID: _____

Prevention Case Management

Client Information

Intervention Characteristics			
What specific activities did the client participate during this session? <i>(Choose all that apply)</i>			
<input type="checkbox"/> HIV testing <input type="checkbox"/> Referral <input type="checkbox"/> Personalized risk assessment <input type="checkbox"/> Elicit partners <input type="checkbox"/> Notification of exposure <input type="checkbox"/> Post-intervention follow up <input type="checkbox"/> Post-intervention booster session <input type="checkbox"/> HIV Testing History Survey <input type="checkbox"/> Other <u>Other testing</u> <input type="checkbox"/> Pregnancy <input type="checkbox"/> STD <input type="checkbox"/> Viral hepatitis	<u>Information</u> <input type="checkbox"/> HIV/AIDS transmission and risk reduction <input type="checkbox"/> HIV risk free behavior <input type="checkbox"/> Viral hepatitis <input type="checkbox"/> Availability of HIV/STD counseling and testing <input type="checkbox"/> Availability of partner notification and referral services <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of social services <input type="checkbox"/> Availability of medical services <input type="checkbox"/> Other sexually transmitted diseases	<u>Demonstration</u> <input type="checkbox"/> Condom/barrier use <input type="checkbox"/> Risk reduction for IDUs <input type="checkbox"/> Negotiation and communication <input type="checkbox"/> Decision making <input type="checkbox"/> Disclosure <input type="checkbox"/> Providing prevention services <input type="checkbox"/> Other <u>Counseling</u> <input type="checkbox"/> Sexual risk reduction <input type="checkbox"/> IDU risk reduction <input type="checkbox"/> HIV testing <input type="checkbox"/> Other sexually transmitted diseases <input type="checkbox"/> Disclosure of HIV status <input type="checkbox"/> Partner notification <input type="checkbox"/> HIV medication therapy adherence <input type="checkbox"/> Other	<u>Practice</u> <input type="checkbox"/> Condom/barrier use <input type="checkbox"/> Risk reduction for IDUs <input type="checkbox"/> Negotiation and communication <input type="checkbox"/> Decision making <input type="checkbox"/> Disclosure <input type="checkbox"/> Providing prevention services <input type="checkbox"/> Other <u>Distribution</u> <input type="checkbox"/> Male condoms <input type="checkbox"/> Female condoms <input type="checkbox"/> Safe sex kits <input type="checkbox"/> Safer injection/bleach kits <input type="checkbox"/> Lubricants <input type="checkbox"/> Education materials <input type="checkbox"/> Referral lists <input type="checkbox"/> Role model stories <input type="checkbox"/> Other
Unit of Delivery: <i>(Choose only one)</i> <input type="checkbox"/> Individual <input type="checkbox"/> Large Group <input type="checkbox"/> Couple <input type="checkbox"/> Community <input type="checkbox"/> Small Group	Delivery Method: <i>(Choose all that apply)</i> <input type="checkbox"/> In person <u>Printed Materials</u> <input type="checkbox"/> Internet <input type="checkbox"/> Magazines/newspapers <input type="checkbox"/> Radio <input type="checkbox"/> Pamphlets/brochures <input type="checkbox"/> Posters/billboards <input type="checkbox"/> Telephone <input type="checkbox"/> Television <input type="checkbox"/> Video <input type="checkbox"/> Other		

Client Unique ID: _____