

# Rapid Session: Session Documentation Form (Required)

Client ID Number: _____ Session ID Number: _____ Site Number: _____ Risk Reduction Specialist ID Number: _____ Session Date: _____	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Referral to:</th> <th style="text-align: center; border-bottom: 1px solid black;">Date Made</th> <th style="text-align: center; border-bottom: 1px solid black;">Date Confirmed</th> </tr> </thead> <tbody> <tr><td>STD:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Drug Trmt:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Family Plnng:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Prenatal/OB:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>TB:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>CHC/PHC:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Mental Health:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>HIV/Prev:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>CRCS/PCM:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Alcohol Trmt:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Immunization:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>Med. Ev. (HCV):</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>HIV Services (HIV+):</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>EBI:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>EBI Name:</td><td colspan="2">_____</td></tr> <tr><td>Other:</td><td style="text-align: center;">___/___/___</td><td style="text-align: center;">___/___/___</td></tr> <tr><td>No Referrals Indicated</td><td colspan="2" style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Follow-Up Method:</td><td colspan="2">_____</td></tr> <tr><td> </td><td colspan="2">_____</td></tr> <tr><td> </td><td colspan="2">_____</td></tr> <tr><td> </td><td colspan="2">_____</td></tr> </tbody> </table>	Referral to:	Date Made	Date Confirmed	STD:	___/___/___	___/___/___	Drug Trmt:	___/___/___	___/___/___	Family Plnng:	___/___/___	___/___/___	Prenatal/OB:	___/___/___	___/___/___	TB:	___/___/___	___/___/___	CHC/PHC:	___/___/___	___/___/___	Mental Health:	___/___/___	___/___/___	HIV/Prev:	___/___/___	___/___/___	CRCS/PCM:	___/___/___	___/___/___	Alcohol Trmt:	___/___/___	___/___/___	Immunization:	___/___/___	___/___/___	Med. Ev. (HCV):	___/___/___	___/___/___	HIV Services (HIV+):	___/___/___	___/___/___	EBI:	___/___/___	___/___/___	EBI Name:	_____		Other:	___/___/___	___/___/___	No Referrals Indicated	<input type="checkbox"/>		Follow-Up Method:	_____			_____			_____			_____	
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<b>Client Information</b> State: _____ County: _____ Zip Code: _____ Date of Birth: ___/___/___ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female      Transgender: <input type="checkbox"/> MTF <input type="checkbox"/> FTM UTC: _____ <p style="text-align: center; font-size: small;"><i>place sticker here</i></p> If Confidential Test: Address: _____ Phone Number: _____ Best way to contact: _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> PI/Hawaiian Native <input type="checkbox"/> Other/Multiracial <input type="checkbox"/> Unknown Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																		
Testing Today: <input type="checkbox"/> Yes <input type="checkbox"/> No If not testing, why? _____ HIV: <input type="checkbox"/> Anon <input type="checkbox"/> Conf Lot #: _____ <input type="checkbox"/> HCV <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia Other: _____	Other: _____ Follow-Up Method: _____ _____ _____ _____																																																																		

Reason for Visit: _____ _____ _____
Previously HIV Tested: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last Test: ___/___/___ Result of Last Test: _____
Rapid Test Result: HIV: _____ HIV Result Given: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Preliminary Positive: Did client receive confirmatory test today? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? _____ If testing: <input type="checkbox"/> Anonymous <input type="checkbox"/> Confidential Note: <i>The client cannot test anonymous today if their rapid test was confidential.</i>
Client Perception of Risk:

Summary of Client Risks and Risk Patterns and Triggers:

Number of sex partners in last year: \_\_\_\_\_ Male \_\_\_\_\_ Female      Number of Needle Sharing Partners: \_\_\_\_\_  
Last Possible Exposure/Risk Behavior(s) and Date: \_\_\_\_\_

Past Attempts at Risk Reduction and Current Client Support, Including Services: \_\_\_\_\_

For data entry purposes only:

**Client Risk**

- Sex with Male A V O U
- Sex with Female A V O U
- Injection Drug Use
- IDU/Sharing Equipment
- Uses Drugs with Sex
  - Heroin/Opiates
  - Cocaine
  - Alcohol
  - Marijuana/Pot
  - Inhalants
  - Designer Drugs
  - Amphetamine/Speed/Crystal
  - Unspecified
  - Other

**Other Exposure for HIV and HCV**

- Occupational Exposure
- Other Needle Exposure
- Blood Transfusion/Transplant
- Other Blood Exposure
- Shared Straw to Snort Drugs
- Body Piercing/Tattoo-Unsanitary Conditions
- Blood Transfusion before July 1992
- Blood Clotting Factors before 1987
- Received Hemodialysis (kidney dialysis)
- About 50 or More Lifetime Partners
- Have Sex or Needle Sharing Partners with HIV
- Have Sex or Needle Sharing Partners with HCV

**Risk of Partner(s)**

- Have Sex or Needle Sharing Partners at risk for HIV:
  - Have HIV+ Partners
  - Have Male-male Sex Partners
  - Partners have Multiple Partners
  - Have IDU/Sharing Equipment Partners
  - Other Partner Risk

**Other Factors**

- Sold Sex for Drugs or Money
- Paid for Sex with Drugs or Money
- Homeless
- Migrant
- Client Forced to Have Sex
- Incarcerated
- Client has History of STDs
- Multiple Sex or Needle Sharing Partners