HIV Risk Screening Tool

**Adults and Adolescents 15 Years and Older**

To provide the best care possible, we ask all of our clients the following set of questions.

The information will remain confidential so please be honest and open with your answers.

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk Assessment** | **Answer** | | **Provider Guidance** |
| 1. At any time in your life, has a health care provider ever told you that you were HIV positive? If NO, please skip to questions 2. | YES | NO |  |
| * + If YES, are you currently receiving ART? | YES | NO | Reingage in ART. |
| 1. In the last year, has a healthcare provider tested you for HIV? | YES | NO | Test for HIV. |
| 1. Are you a male between 20 – 59 years of age? | YES | NO | TEST for HIV |
| 1. Do you have any of the following?    * Recurring cough, weight loss, fever, night sweats | YES | NO | TEST for HIV & TB |
| 1. Do you have any of the following on your private parts or genitals?    * Sores, blisters, unusual or smelly discharge | YES | NO | TEST for HIV & treat STI |
| 1. In the last 3-6 months, have you had sex without a condom with a person who’s HIV status you do not know or who might be HIV+? | YES | NO | TEST for HIV |
| 1. In the last 3-6 moths, have you had sex with someone you randomly met? Either through social media or at a social place (tavern, bar)? | YES | NO | TEST for HIV |

HIV Risk Screening Tool

**Children and Adolescents Less than 15 Years of Age**

To provide the best care possible, we ask all of our clients the following set of questions.

The information will remain confidential so please be honest and open with your answers.

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| --- | --- | --- | --- |
| **Risk Assessment** | **Answer** | | **Provider Guidance** |
| 1. Has the child ever had an HIV test? | YES | | Confirm if result was +/- |
| NO | | Proceed to Question 2 |
| * + If YES (i.e. the child was previously tested for HIV), was the test confirmed HIV positive? | YES | | Confirm the child is on ART, and if not, start ART |
| NO | | Confirm child tested HIV- after finished breastfeeding |
| *NOTE: If the child was previously tested for HIV, and the result was* ***negative*** *six weeks following the cessation of breastfeeding, this child* ***does not need*** *another HIV test UNLESS he/she had a new exposure risk.* ***STOP HERE****.* | | | |
| 1. Is this child’s biological mother HIV+? | YES | NO | TEST for HIV |
| 1. Are one or more of this child’s biological parents deceased?    * Sores, blisters, unusual or smelly discharge | YES | NO | TEST for HIV |
| 1. In the last 3 months, has this child been in poor health (more than other children) or been admitted to the hospital? | YES | NO | TEST for HIV |
| 1. Does this child live with someone who has been diagnosed with TB, or have any of the following symptoms of TB?  * cough, fever, poor weight gain, or night sweats | YES | NO | TEST for  HIV & TB |
| 1. Has this child had recurring skin problems? | YES | NO | TEST for HIV |
| 1. Has this child had frequent ear discharge? | YES | NO | TEST for HIV |
| 1. Is this child not growing as well as other children of the same age? For example, is the child shorter or does the child weigh less than other children of the same age? | YES | NO | TEST for  HIV & TB |