**HIV TESTING AND COUNSELLING**

**Form C: Follow-Up Counseling/testing**

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| * **Individual session** | * **Family Present** | * **Partner/spouse Present** |
| **Client/spouse Registration :** | **Date:** | **Counselor Code:** |

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| **Date of Previous HIV testing**  **(as per record)** | **Any Change In Marital**  **Status, as per previous record**  **(if Yes, Specify)** | **Presently Pregnant**  **(only for Female )** |
| **Results**   * Negative * Positive * Indeterminate |  | * Yes * No   If yes, Duration |

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| **Disclosure Details** | | |
| **Have you disclosed your HIV Status** | **If Yes, with Whom** | **Outcome of Disclosure**  **(Specify)** |
| * Yes * No | Name:  Relation: |  |

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| **Psychological Assessment** |
| **Has the Client/Spouse Experienced any of the following, after his/her last HIV test ( HTC )** |
| * A Persistent sad, Anxious or empty mood * Too much or too little sleep * Reduced appetite & weight loss, or increase appetite & weight gain * Withdrawal from friends, relatives or other clients that were previous close * Loss of interest or pleasure in activities once enjoyed * Agitation, restlessness or irritability * Persistent physical symptoms that do not respond to treatment * Difficulty in concentrating, remembering or making decision * Hallucination (hearing voices or seeing things others cannot hear or see) * Fatigue or loss of energy * Feeling of Guilt, Hopelessness or worthlessness * Thoughts of Deaths or Suicide |
| **Specify the thoughts ( Death or Suicide)** |
| **Specify any Suicidal Attempt ( if any)** |

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| **Risk Assessment (since his/her last HTC)** | | |
| **Currently injecting: Yes No** | | |
| **Sharing of your used needle /syringes**  **With someone else**  **Yes**   **No** | **Sharing of the equipments/containers**  **Yes No** | **Injecting with needle/syringe that someone else has used**  **Yes No** |
| If yes, when was the last time you share (specify time) | If yes, when was the last time you share (specify time) | If yes, when was the last time you inject with syringe/needle that someone else has used (specify time) |

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| **Sexual Practices:** | | |
| **When did you have sexual intercourse last Time** | **With Whom did you have your last sexual intercourse** | **During your last sexual intercourse did you use condom** |
| * < 1 month * 1-6 months * > 6 months | * Spouse(Husband/wife) * FSW * MSM/Hijra * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yes * No |

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| **Pre-test Session Checklist** | |
| * Assurance of confidentiality & informed consent | * Assessment of client’s possible reaction to +ve result |
| * Explored & clarified knowledge about HIV | * Assessment of client’s coping mechanisms |
| * Discussed testing process & implication of test results on client | * Review client’s potential needs and available social support |

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| **Client is ready to take follow up HIV Test ( if applicable) Yes No** | | | | |
| **Follow-up HIV test details** | | | | |
| **Date of test** | **Type of test used** | **Results** | **Administered by** | **Results conveyed** |
| 1. |  | * Positive * Negative * Indeterminate |  | * Yes * No |
| 2. |  | * Positive * Negative * Indeterminate |  | * Yes * No |
| 3. |  | * Positive * Negative * Indeterminate |  | * Yes * No |

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| **Client’s reaction after results announcements** | **Trust to share Information With** | **Reason for non-disclosure**  **(if client is not willing for disclosure)** | **Condom Provision** |
| Comments : | Name:  Relationship: | * Fear of non-acceptance * Fear of losing relationship * Lack of social /emotional support * Denial * Anxiety / depression * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Offered * Accepted |

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| **Counseling Sessions** | | |
| **Key Issues** | **Remarks** |
| Orientation of HIV & AIDS & about Testing Procedure |  |
| Partner/Family notification  ( Disclosure counseling) |  |
| Partner/family Test |  |
| Safer Sexual Practices |  |
| Safer Injecting Practices |  |
| Stress coping mechanism |  |
| Soc-economic support |  |
| Health Related Issues |  |
| Referrals Linkages |  |
| Need for Follow up |  |
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Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_