For clinician use only:

☐ **At risk for TB**
(Based on positive response to any question 9-14).

INFECTIOUS DISEASE MEDICAL SCREEN

Name_____Date _____

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state Law authorizes the disclosure.

☐ I have read and understand the above. Signature: _____

Please mark the one most accurate response to each question.

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)?

   ☐Yes ☐ No

2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)?

   ☐Yes ☐ No

3. Are you a recipient of clotting factor made prior to 1987?

   ☐Yes ☐ No

4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood?

   ☐Yes ☐No

5. Were you born to a mother who had hepatitis?

   ☐Yes ☐No

6. Have you ever had symptoms of liver disease or abnormal liver function/enzyme tests?

   ☐ Yes ☐ No

7. Have any of your sexual partners been infected with hepatitis B or C?

   ☐Yes ☐ No

8. Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. unsterile needles)?

   ☐Yes ☐No

9. Mark all of the following that currently apply to you or that applied to you in the past.

☐ **Close** contact with active TB

☐ Medical condition that increases risk of **TB** disease (e.g., HIV, other immune disorders, diabetes, silicosis,[black lung] or coal miners disease}, bleeding/clotting disorders, specific malignancies, kidney failure, etc.)

☐ Abnormal chest x-ray showing fibrotic lesions

☐ Resident or employee of a high risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.)

☐ Health care worker or volunteer who serves high-risk clients

☐ Foreign-born person who has arrived within the last five years from countries that have a high **TB** incidence or prevalence (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)

☐ Person from a medically underserved, low-income population

☐ Member of a high-risk racial, ethnic, or other minority population with an increased prevalence of TB (e.g" Asian and Pacific Islanders, Hispanics, African-Americans, Native Americans, migrant farm workers, homeless persons)

☐ History of inadequately treated TB

10. Have you had a cough for more than three weeks?

☐ Yes ☐ No

11. Have you coughed up blood/colored mucous?

☐ Yes ☐ No

12. Do you have swollen, non-tender lymph nodes?

☐ Yes ☐ No

13. Have you had a prolonged loss of appetite or unexplained weight loss of ten pounds or more?

☐ Yes ☐ No

14. Have you had recurrent fevers or heavy night sweats for more than three weeks?

☐ Yes ☐ No

Response Guide:

If you answered "yes" to any question # 1-7, please see your counselor for a referral to be screened for hepatitis B and C.

If you answered "yes" to question # 8, please see your counselor for a referral for infectious disease screening and testing.

If you answered "yes" to any of the categories in question # 9, please see your counselor for a referral to be screened for tuberculosis.

If you answered "yes" to any question # 10-14, please see your counselor immediately for a referral for tuberculosis screening and treatment.

Your counselor is referring you to the following program/agency for follow-up:

Program/Agency:_____

Address:_____

Contact:_____ **Phone:**_____

For clinician use only:

□At risk for HIV

If so is at :

☐ Medium risk

☐High risk

Score:

INFECTIOUS DISEASE BEHAVIORAL SCREEN

Name:_____ Date:_____

I understand that my responses to this Screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F .R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV I STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

☐I have read and understand the above. Signature:_____

Please mark the one most accurate response to each question.

1. Have you had 2 or more sexual partners in the past 10 years?

   ☐Yes ☐ No

2. Have you had anal sex (penis in anus) with any of your sexual partners during the past 10 years?

   ☐ Yes ☐ No

3. How often have you used a condom when having anal sex in the past 10 years?

   ☐ Never ☐ Sometimes ☐ Always ☐ Have not had anal sex

4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?

   ☐ Yes ☐ No

5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?

   ☐ Yes ☐ No

6. Have you ever had sex with someone so that they would give you money or drugs?

   ☐ Yes ☐ No

7. Have you ever injected street drugs, steroids, or vitamins with a needle?

   ☐ Yes ☐ No

8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?

   ☐ Yes ☐ No ☐ Don't know

9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?

   ☐ Yes ☐ No ☐ Don't know

10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?

    ☐Yes ☐No ☐ Don't know