SPOTS EXAMPLE CLIENT ASSESSMENT FORM

TEST ID	CLIENT ID (optional)	DATE OF VISIT
TEST LOCATION	TEST COUNSELOR	PROGRAM AWARD ☒_____

CLIENT INFORMATION

First Name:	Middle Initial:	Last Name:	
Date of Birth:	State of Residence:	County:	Zip Code:

Ethnicity

☐Not Hispanic or Latino
☐Hispanic or Latino (*select subgroup*)
☐Declined to Answer

Hispanic Subgroups

☐Mexican, Chicano, Mexican-American
☐Puerto Rican
☐Cuban
☐Other

Race (Check All That Apply)

☐American Indian/Alaskan ☐Native Black/African American ☐White ☐Declined to Answer

☐Native Hawaiian/Pacific Islander (select subgroup)

☐Native Hawaiian, Guamanian, Chamorro
☐Samoan
☐Other Pacific Islander

☐Asian (select subgroups)

☐Asian Indian ☐Korean
☐Chinese ☐Vietnamese
☐Filipino ☐Other Asian
☐Japanese

Health Insurance

☐Indian Health Service
☐Medicaid, CHIP, Other Public Plan
☐Private Employer
☐Private Individual
☐VA, Tricare, Other Military
☐Medicare
☐Other Insurance
☐No Insurance

Sex Assigned At Birth

☐Male
☐Female
☐Declined to Answer

Current Gender ID

☐Man
☐Woman
☐Transgender: Male to Female
☐Transgender: Female to Male
☐Transgender: Unspecified
☐Another Gender
☐Declined to Answer

CLIENT ASSESSMENT

do not leave any items blank

Has the client had a previous HIV test?	Has the client had a previous positive HIV test?	Date of previous positive test:
☐Yes ☐No ☐Does Not Know ☐Declined	☐Yes **(I)** ☐No ☐Does Not Know	

	Within the past 5 years has the *client*:		Within the past 5 years has a *sexual partner*:		
I/P (if MSM or TGW)	Had sex with a male?	☐Yes ☐No ☐DK	Injected drugs?	☐Yes ☐No ☐DK	P
	Had sex with a female?	☐Yes ☐No ☐DK	Identified as MSM? *(if female or TGW)*	☐Yes ☐No ☐DK	P
	Had sex with a transgender person?	☐Yes ☐No ☐DK	Exchanged sex for drugs/money/goods?	☐Yes ☐No ☐DK	P
I/P	Been diagnosed with an STI?	☐Yes ☐No ☐DK	Tested positive for hepatitis A or B?	☐Yes ☐No ☐DK	I
I	Been diagnosed with HCV?	☐Yes ☐No ☐DK	**PrEP Awareness and Use**		
P	Exchanged sex for drugs/money/goods?	☐Yes ☐No ☐DK	Has the client ever heard of PrEP?	☐Yes ☐No	
I	Used non-injection drugs?	☐Yes ☐No ☐DK	Taken PrEP in the past 12 months?	☐Yes ☐No	
I/P	Had sex with someone living with HIV?	☐Yes ☐No ☐DK	Is the client currently taking PrEP?	☐Yes ☐No	

Has the client ever:

I/P/C	Used injection drugs?	☐Yes (within the last five years) **PSA** ☐Yes (more than five years ago) ☐No ☐Does Not Know

Type of drug/s injected:

Definitions and Key

If the client answers YES to any related question:
P = Indicated for PrEP
I = Indicated for hepatitis A/B Immunization
C = Indicated for hepatitis C Testing
PSA = PWID Supplemental Assessment

Acronym Definitions:

MSM = man who has sex with men
TGW = Transgender Woman

CLIENT ASSESSMENT NOTES (*OPTIONAL*)

SERVICES					
HIV Test:	☐Yes ☐No	**Hepatitis A Immunization:**	☐Yes ☐No	**Syphilis Test:**	☐Yes ☐No
HCV Test:	☐Yes ☐No	**Twinrix Immunization:**	☐Yes ☐No	**Gc/Ct Test:**	☐Yes ☐No
PWID Assessment:	☐Yes ☐No				

HIV Test Results and Services

Test Type	Rapid Test Result	Rapid Positive (Determine Only)	IF RAPID POSITIVE	Confirmatory Test Administered	If NO, Why?	Test Result Provided to Client?
☐Insti ☐Determine ☐Conventional ☐At-Home Rapid ☐At-Home Conventional ☐Other	☐Negative ☐Preliminary Positive ☐Invalid	☐Antigen ☐Antibody ☐Both		☐Yes ☐No	☐Declined ☐Lost ☐Previous +	☐Yes ☐No

^ if test type is 'conventional' or 'at-home self-collected' proceed directly to 'confirmatory test result section'

If a client has a rapid reactive HIV test result and confirmatory test is not administered or the client cannot be notified of the confirmatory test result, please follow the 'lost to follow up' procedure outlined in the program manual.

Confirmatory Test Result

☐HIV-1 Reactive
☐HIV-2 Reactive
☐HIV Negative
☐Inconclusive
☐Invalid
☐Discordant

Client Negative for HIV	
PrEP	
Client indicated for PrEP:	☐Yes ☐No
Provided PrEP counseling/education:	☐Yes ☐No (user)
Provided with services to assist w/ linkage:	☐Yes ☐No (declined)
Referred to PrEP provider:	☐Yes ☐No (declined)
Referrals and Other Services	
Social Services:	☐Yes ☐No
Behavioral Health Services:	☐Yes ☐No
Health Benefits Navigation/Enrollment:	☐Yes ☐No
Counseled on Prevention Strategies:	☐Yes ☐No

Client Diagnosed with HIV	
Was the client referred to medical care:	☐Yes ☐No
Client attended first medical appointment: If 'YES' - Date of First Appointment:	☐Yes (self-report) ☐Yes (confirmed) ☐No ☐Unknown
Client linked to Ryan White Support Services:	☐Yes ☐No
Client provided risk reduction counseling:	☐Yes ☐No
HIV dx reported to Iowa HHS:	☐Yes ☐No
Client Housing Status:	☐Literally Homeless ☐Unstable Housing ☐Stable Housing ☐Unknown ☐Declined
For HIV + People Who Can Become Pregnant	
Is client pregnant:	☐Yes ☐No
If so, in prenatal care:	☐Yes ☐No
Linked to perinatal services:	☐Yes ☐No

HCV Test Results and Services

		Complete if Rapid Reactive			
Test Type	**Rapid Test Result**	**Confirmatory Test Administered**	**Confirmatory Test Result (antibody)**	**Confirmatory Test Result (viral load detected)**	**Test Result Provided to Client?**
☐Rapid ☐Conventional ☐At-Home Conventional ☐Other	☐Negative ☐Preliminary Positive ☐Invalid	☐Yes ☐No	☐Negative ☐Positive/Reactive	☐Yes ☐No	☐Yes ☐No

^ if test type is 'conventional' or 'at-home self-collected' proceed directly to 'confirmatory test result section' ^

If a client has a rapid reactive HCV test result and confirmatory test is not administered or the client cannot be notified of the confirmatory test result, please follow the 'lost to follow up' procedure outlined in the program manual.

Client Diagnosed with HCV (viral load detected)

Referred for treatment navigation services:	☐Yes ☐No (does not qualify) ☐No (declined) ☐No	**IF 'NO' for 'referred to treatment navigation services**	Referred to medical care:	☐Yes ☐No (declined)

Hepatitis Immunization Services

Immunization Type	IRIS #	Dose Tracking
☐Twinrix ☐Hepatitis A		☐ Dose 1 ☐ Dose 2 ☐Dose 3

STI Results and Treatment / Referral Services			
	Chlamydia	**Gonorrhea**	**Syphilis**
Method of Collection:	☐Rectum ☐Throat ☐Urethra ☐Urine ☐Vagina ☐Other		
Positive Test Results:	☐Rectum ☐Throat ☐Urethra ☐Urine ☐Vagina ☐Other	☐Rectum ☐Throat ☐Urethra ☐Urine ☐Vagina ☐Other	☐New Infection
Received Treatment:	☐Yes – Referred ☐Yes – Treated In House ☐Pending ☐Unknown ☐No	☐Yes – Referred ☐Yes – Treated In House ☐Pending ☐Unknown ☐No	☐Yes – Referred ☐Yes – Treated In House ☐Pending ☐Unknown ☐No
Treatment Verified:	☐Yes ☐No ☐Pending ☐Unknown	☐Yes ☐No ☐Pending ☐Unknown	☐Yes ☐No ☐Pending ☐Unknown
If NOT Treated, Why:	☐Declined ☐Lost to Follow Up	☐Declined ☐Lost to Follow Up	☐Declined ☐Lost to Follow Up
Reported to HHS:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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PWID SUPPLEMENTAL ASSESSMENT

Hepatitis B Surface Antigen Screening			
Client Tested for Hepatitis B?	☐Yes ☐No	**Date Sample Submitted to SHL:**	_____/_____/_____
HBsAg Test Result:	☐Reactive ☐Non-reactive	**Client Notified of Test Result?**	☐Yes ☐No – Could Not Locate
If Reactive **Was Client Linked to Care?**	☐Yes ☐No – Could Not Locate ☐No – Declined	**Notes (*optional*):**	

Substance Use Disorder (SUD) Screening			
Client Screened for SUD?	☐Yes ☐No	**Screening Tool:**	☐SBIRT ☐DAST ☐AUDIT ☐OTHER _____
Screening Result:	SBIRT: ☐Positive ☐Negative AUDIT: ☐Positive ☐Negative DAST: ☐Positive ☐Negative OTHER: ☐Positive ☐Negative		
If indicated, was the client referred to SUD treatment services?	☐Yes ☐No –Declined	**Notes (*optional*):**	

Screening for Bacterial and Fungal Complications of Injection Drug Use			
Client Screened for Medical Complications?	☐Yes ☐No	If yes, complete the following table. If any complications are reported as present, refer the patient to immediate emergency medical services as they can be fatal if untreated.	
Possible Complication	**Description/Characterizations**	**Present**	**Referred for Evaluation**
Bacteremia	Chills, fever, extreme fatigue.	☐Yes ☐No	☐Yes ☐No - Declined
Endocarditis	Heart murmur, fever, chest pain, fainting spells, shortness of breath, and/or heart palpitations.	☐Yes ☐No	☐Yes ☐No - Declined
Tetanus	Muscle spasms or rigidity, especially in the neck / jaw.	☐Yes ☐No	☐Yes ☐ No - Declined
Necrotizing Fasciitis	Increasing redness, swelling, and extreme pain at the wound or injection site accompanied by fever. Skin may turn from red/purple to blue/grey and begin breaking down in 3-5 days.	☐Yes ☐No	☐Yes ☐No - Declined
Wound Botulism	Droopy eyelids, blurred or double vision, and a dry/sore throat that may progress into difficulty speaking and swallowing, a weakness of the neck, arms, and legs, and difficulty breathing.	☐Yes ☐No	☐Yes ☐No - Declined
Abscesses	Presence of hard/warm lumps at the injection site. Concurrent with fever or chills, extreme fatigue, associated pain, or a thin and dark line moving from the abscess are cause for immediate medical attention.	☐Yes ☐No	☐Yes ☐No - Declined

Hepatitis A and B Immunizations		
Client Vaccination Status:	☐Previously Vaccinated – Complete (Twinrix) ☐Previously Vaccinated – Partial Twinrix ☐Previously Vaccinated – Hep A Only ☐Unvaccinated ☐Previously Vaccinated – Hep B Only	
Vaccination Services or Referrals:	☐Vaccines Provided Twinrix ☐Vaccines Provided Hep B ☐Declined Vaccinations - ☐Referred for Vaccinations ☐Declined Referral	☐Dose 1 ☐Dose 2 ☐Dose 3 ☐Dose 1 ☐Dose 2 ☐Dose 3 **Notes (*optional*):**

Other Services or Referrals	Notes (*optional*):
☐Harm Reduction Supplies Distributed	
☐Condoms/Risk Reduction Supplies Distributed	
☐Referred to Syringe Disposal Services	
☐Naloxone Supplies (referred or distributed)	