

Comprehensive Risk Counseling Services
Referral Form

Date ___/___/20___	Worker Name _____ Worker Phone _____
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Client Name First: _____ Last: _____

DOB ___/___/_____

(If HIV Positive) Date Tested HIV Positive ___/___/_____

In the past 90 days:

	No	yes	decline	Don't know
Have you shared unclean works (such as needles or syringes) with someone?	___	___	___	___
Have you had unprotected sex with anyone (male, female, transgender)	___	___	___	___
Have you had sex with someone whose HIV status you did not know?	___	___	___	___
Have you had sex with someone whose HIV status you knew was different from yours?	___	___	___	___
Have you been diagnosed with Syphilis, Chlamydia, or Gonorrhea?	___	___	___	___
Have you had sex while high on drugs or alcohol?	___	___	___	___
Have you exchanged sex for money, drugs, shelter, etc.?.....	___	___	___	___
If prescribed HIV medication, have you had trouble taking your HIV medication as prescribed by your doctor?.....	___	___	___	___

Best address for contacting client

Street _____

City _____

State _____ Zip _____

Can client be contacted by phone/email/other way? Yes ___ No ___

Home _____ Work _____

Cell _____ Text _____

Email _____ Other (way) _____