**HIV RISK STRATIFICATION TOOL (age 14 years or older) (Version October 2019)**

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F Age (years) \_\_\_\_\_\_\_\_\_\_

***Introduction:*** *I’m going to ask you some questions to better understand your HIV risk. These can be very personal questions and may be hard to answer. In order to accurately understand your risk for HIV, I need to ask these questions and I need you to answer them as honestly as possible. If you need a moment to think before answering that is fine. Whatever we discuss will remain confidential.*

***Note: When using the tool, if someone reports never having an HIV test remove “since your last HIV test” from the beginning of the question.***

|  |  |  |
| --- | --- | --- |
| Is this HIV test based on a Clinician/Doctor/Health Care Provider’s request? | YES  NO | If **YES**, test for HIV.  If **NO**, proceed to question 1 |
| 1a When was your last HIV test done? \_\_\_\_\_\_\_\_\_\_\_\_\_  (approximate date of last HIV test in years, months or weeks)  1b. What was the result? | NEVER  UNKNOWN  POS  NEG | If positive, confirm patient is on ART. If no ART, link to ART  If**, NEG, NEVER,** or **UNKNOWN**, – ask question 2 |
| 2. Since your last HIV test, have you had anal or vaginal or oral sex without a condom with someone who was HIV positive or unaware of their HIV status? | YES  NO | If **YES**, test for HIV.  If **NO**, ask question 3. |
| 3. Since your last HIV test, have you had a blood or blood product transfusion? | YES  NO | If **YES**, test for HIV.  If **NO**, ask question 4. |
| 4. Since your last HIV test, have you experienced painful urination, lower abdominal pain, vaginal or penile discharge, pain during sexual intercourse, thick, cloudy, or foul smelling discharge and/or small bumps or blisters near the mouth, penis, vagina, or anal areas? | YES  NO | If **YES to any of the symptoms**, test for HIV.  If **NO**, ask question 5. |
| 5. Have you been diagnosed with TB or currently have any of the following symptoms: cough, fever, weight loss, night sweats? | YES  NO | If **YES**, test for HIV and TB.  If **NO**, ask question 6. |
| 6. Since your last HIV test, have you ever injected drugs, shared needles or other sharp objects with someone known to be HIV positive or who you didn’t know their HIV status? | YES  NO | If **YES**, test for HIV.  If **NO**, ask question 7. |
| 7. Since your last HIV test, have you had anal, oral or vaginal sex in exchange for money or other benefits? | YES  NO | If **YES**, test for HIV.  If **NO**, ask question 8. |
| 8. Since your last HIV test, have you been forced to have sex? | YES  NO | If **YES**, test for HIV and provide GBV services.  If **NO**, do **NOT** test for HIV and proceed with clinical visit. |

**ELIGIBLE FOR HIV TESTING? YES NO**