MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

LHD PARTNER SERVICES FEEDBACK FORM

February 2016

Please collect items below from each client during counseling and return to HIV Surveillance staff via fax.
Pre-program your secure fax to HIV Surveillance: 248-424-9161. Questions: 248-424-7910

Client Name: Last_____ First_____ Middle _____

Date of Birth: _____/_____/_____ Stateno: _____ Interview Date: _____

Date information obtained from client (month/day/year): ____/____/_____

Person Completing Form: Last_____ First_____ Phone ( ) _____-_____

Race : __ Black/AA __ White __ Am Indian/Alaskan __ Asian __ Native Hawaiian/PI __ Refused

Ethnicity: __ Latino/Hispanic __ Arabic __ Neither __ Refused

Risk/Exposure Factors (check all that apply):

Before HIV Diagnosis, patient had:	Y	N	Unk	Before HIV Diagnosis, patient had:	Y	N	Unk
Sex with a male				*HETEROSEXUAL SEX WITH:*			
Sex with a female				*- An injection drug user (IDU)*			
Injected non-prescription drugs				*- A bisexual male (females only)*			
Transplant/transfusion/clotting disorder*				*- Person known to have HIV/AIDS*			
**and is claiming this as their source of HIV infection*							
Was Patient Perinatally Infected?				Was Patient having high risk sex?			

Testing and ARV use history per client: (partial dates acceptable)

Date questions answered by patient: _____/_____/_____

Main Source of TTH Info: ☐ Medical Record Review ☐ Patient Interview ☐ Provider Report ☐ Other

First Positive Test Reported by Patient:	**Negative Tests Reported by Patient:**
Ever have previous positive HIV test? ☐ Y ☐ N ☐ Unk	Ever test negative? ☐ Y ☐ N ☐ Unk
Date of 1st positive HIV test:_____/_____/_____	Date of most recent negative test: _____/_____/_____
Anonymous 1st positive test? ☐ Y ☐ N ☐ Unk	# of negative tests in 24 mo. before 1st positive test:_____ ☐ Unk

History of ANY Antiretroviral Treatment (ARV) Use: CHECK HERE IF NO ARV USE EVER: ☐

For HIV Tx? ☐ ARV used:_____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For PrEP? ☐ ARV used:_____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For PEP? ☐ ARV used:_____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For Preg mom? ☐ ARV used:_____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For Hep B Tx? ☐ ARV used:_____ Date began: _____/_____/_____ Date of last use: _____/_____/_____

Currently using ARV? ☐ Yes, Date of most recent use: _____/_____/_____ ☐ No, Date of last use: _____/_____/_____

Reason client not counseled by Partner Services:

___Unable to locate ___Out of jurisdiction
___Refused/Declined ___Incapacitated
Other: _____

Comments:_____

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