

Pre-Exposure Prophylaxis (PrEP) Screening for Substantial Risk and Eligibility

1. Facility Information		
Facility Name		
Date of Initial Client Visit (dd/mm/yyyy) ___/___/_____		Person Completing Form
2. Client Information		
First Name	Middle Name	Surname
Address	Telephone #	
Client ID Number		
3. Client Demographics		
What was your sex at birth?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> No response	
What is your current gender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (male to female) <input type="checkbox"/> Transgender (female to male) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> No response	
What is your age? (Specify number of years.)	_____	
4. Screening for Substantial Risk for HIV Infection		
Client is at substantial risk if he/she belongs to categories 1, 2, or 3 below	Question Prompts for Providers	
1 If client is sexually active in a high HIV prevalence population PLUS reports ANY one of the below in the last 6 months	Have you been sexually active in the last 6 months?	
<input type="checkbox"/> Reports vaginal or anal intercourse without condoms with more than one partner	In the last 6 months, how many people did you have vaginal or anal sex with? In the last 6 months, did you use condoms consistently during sex?	
<input type="checkbox"/> Has a sex partner with one or more HIV risk:	In the last 6 months, have you had a sex partner who: <ul style="list-style-type: none"> • Is living with HIV? • Injects drugs? • Has sex with men? • Is a transgender person? • Is a sex worker? • Has sex with multiple partners without condoms? 	
<input type="checkbox"/> History of a sexually transmitted infection (STI) based on self-report, lab test, syndromic STI treatment	In the last 6 months, have you had an STI?	
<input type="checkbox"/> History of use of post-exposure prophylaxis (PEP)	In the last 6 months, have you taken post-exposure prophylaxis (PEP) following a potential exposure to HIV?	
2 If client reports history of sharing injection material or equipment in the last 6 months <input type="checkbox"/> History of sharing injection material or equipment	In the last 6 months, have you shared injecting material with other people?	
3 If client reports having a sexual partner in the last 6 months who is HIV positive AND who has not been on effective* HIV treatment (i.e., the partner has been on ART for fewer than 6 months or has inconsistent or unknown adherence) <input type="checkbox"/> History of HIV-positive sex partner not on effective treatment	Is your partner HIV positive? Is he/she on ART? What was the last viral load result?	

5. PrEP Eligibility	
Client is eligible if he/she fulfills ALL the criteria below:	
<input type="checkbox"/> HIV negative	Date client tested: (dd/mm/yyyy): ___ / ___ / _____ Date client received test results: (dd/mm/yyyy): ___ / ___ / _____ Test result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (Refer to HIV medical care.) <input type="checkbox"/> Inconclusive (Re-test in 14 days.) Type of test used: <input type="checkbox"/> Determine <input type="checkbox"/> Unigold <input type="checkbox"/> ELISA <input type="checkbox"/> Other (specify):
<input type="checkbox"/> At substantial risk of HIV	At least one item/risk in Section #4 above is ticked
<input type="checkbox"/> Has no signs/symptoms of acute HIV infection	See Section #6 below to confirm no recent exposure to HIV
<input type="checkbox"/> Has creatinine clearance (eGFR) >60 ml/min	Result: _____ Date of creatinine test (dd/mm/yyyy): ___ / ___ / _____
If all boxes in Section 5 are ticked, offer PrEP.	

6. Recent Exposure to HIV			
<i>Ask the client:</i> In the past 72 hours, have you had sex without a condom with someone whose HIV status is positive or not known to you, or have you shared injection equipment with someone whose HIV status is positive or unknown to you?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
In the past 28 days, have you had symptoms of a cold or flu, including fever, fatigue, sore throat, headache, or muscle pain or soreness?	<input type="checkbox"/> Yes**	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
* If the client reports potential exposure to HIV within past 72 hours, do NOT offer PrEP. Follow facility procedures to evaluate further or refer for evaluation for post-exposure prophylaxis (PEP). ** If the client reports flu-like symptoms or other signs of acute HIV infection, do NOT offer PrEP and evaluate further, following facility procedures to diagnosis acute HIV infection.			

7. Services Received by Client
<input type="checkbox"/> PrEP offered. <ul style="list-style-type: none"> • <input type="checkbox"/> PrEP accepted. • <input type="checkbox"/> PrEP declined. (If declined, see Reasons for Declining PrEP, below).
Date eligible (dd/mm/yyyy): ___ / ___ / _____
Date initiated (dd/mm/yyyy): ___ / ___ / _____ <i>Same-day initiation recommended.</i>
Reasons for Declining PrEP <i>(Check all that apply.)</i>
<input type="checkbox"/> No need for PrEP
<input type="checkbox"/> Does not wish to take a daily medication
<input type="checkbox"/> Concerns about side effects
<input type="checkbox"/> Concerns about what others might think
<input type="checkbox"/> Concerns about time required for clinic follow-up
<input type="checkbox"/> Concerns about safety of medication
<input type="checkbox"/> Concerns about effectiveness of medication
<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Referred for PEP evaluation

Referred for PCR/HIV Ag test or follow-up HIV re-testing (if suspicion of acute HIV infection)