### **Network-Based Testing Services: Model Integrated Tool for Modality and Testing Type Selection**

*This tool has not been field tested for use. Field testing and adaptation of the tool will improve its usability for distinct settings and populations.*

**Client Information**

|  |  |
| --- | --- |
| **Field** | **Details** |
| **Client Name** |  |
| **Date of Visit** |  |
| **Healthcare Provider** |  |

### **Instructions:**

1. **Step 1**: Fill out the **Client Profile** (key information) in the table below.
2. **Step 2**: Complete testing results section and proceed to the corresponding section.
3. **Step 3**: Based on the test results, fill out the modality selection tables for each type of test.

### **Step 1: Client Profile**

|  |  |  |
| --- | --- | --- |
| **Question** | **Answer (Yes/No)** | **Notes** |
| Is the client part of a key population?  | ☐ Yes ☐ No | If “yes,” please specify:☐ MSM ☐ FSW ☐ PWID ☐ Prison or closed setting ☐ Trans/gender diverse |
| Does the client have children? | ☐ Yes ☐ No | If “yes,” please specify how many: |
| Does the client live with other children (not their biological children)? | ☐ Yes ☐ No | If “yes,” please specify how many & relationship to client: |
| Is the client sexually active (within the past year)? | ☐ Yes ☐ No |  |
| Has the client previously been diagnosed with any STIs? | ☐ Yes ☐ No | If “yes,” please specify which STI they have been diagnosed with, and when: |
| Has the client previously experienced STI symptoms? | ☐ Yes ☐ No | If “yes,” please specify what symptoms were experienced: |
| Has the client previously taken treatment for any STIs? | ☐ Yes ☐ No | If “yes,” please specify what STI was treated and when: |
| Has the client received any vaccinations for HBV? | ☐ Yes ☐ No☐ Not sure |  |

### **Step 2: Identify Test Types**

Please mark (✓) the test types you are assessing for the patient, and fill out the test results (positive, negative, inconclusive, or a presumptive diagnosis based on symptoms):

|  |  |
| --- | --- |
| **Infection Type** | **Test Results** |
| **☐ HIV** | ☐ Positive ☐ Negative ☐ Inconclusive |
| **☐ Hepatitis B (HBV) sAg** | ☐ Positive ☐ Negative ☐ Inconclusive |
| **☐ Hepatitis C (HCV) Ab** | ☐ Positive ☐ Negative ☐ Inconclusive |
| **☐ Syphilis, specify test type:** | ☐ Positive ☐ Negative ☐ Inconclusive |
| **☐ Other STIs: chlamydia** | ☐ Positive ☐ Negative ☐ Symptom-based diagnosis |
| **☐ Other STIs: gonorrhea** | ☐ Positive ☐ Negative ☐ Symptom-based diagnosis |
| **☐ Other STIs: herpes simplex** | ☐ Positive ☐ Negative ☐ Symptom-based diagnosis |
| **☐ Other STIs: genital warts / HPV** | ☐ Positive ☐ Negative ☐ Symptom-based diagnosis |
| **☐ Other STIs (list):**  | ☐ Positive ☐ Negative ☐ Symptom-based diagnosis |

### If the client tests positive for any of the above infections, please find the infection below and fill out the corresponding sections.

### **Step 3: Testing Modality Selection by Infection Type**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Test Positive Results**  | **Complete Section A (Partner services)** | **Complete Section B (Social network testing)** | **Complete Section C (Family and household testing)** |
| HIV | Yes | Yes | Yes |
| Chlamydia, herpes simplex, or HPV/genital warts | Yes | Yes |  |
| Syphilis or gonorrhea | Yes | Yes | Yes |
| Hepatitis B | Yes |  | Yes |
| Hepatitis C | Yes |  |  |

If the patient is positive for **HIV**, please complete sections **A (partner services), B (social network testing), and C (family & household testing)** below

If the patient is positive for **a chlamydia, herpes simplex, or HPV / genital warts**, please complete sections **A (partner services) and B (social network testing)** below

If the patient is positive for **syphilis or gonorrhea**, please complete sections **A (partner services), B (social network testing), and C (family and household testing)** below

If the patient is positive for **hepatitis B**, please complete sections **A (partner services) and C (family & household testing)** below

If the patient is positive for **hepatitis C**, please complete section **A (partner services)** below

**Section A – Partner Services**

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Answer (Yes/No)** |  |  |
| Has the client had sexual partners in the last 3 years?  | ☐ Yes ☐ NoIf yes, please fill out “sexual partners” below for each partner |  |  |
| Has the client had drug injection partners in the last 3 years?  | ☐ Yes ☐ NoIf yes, please fill out “injection partners” below for each partner |  |  |
| **List of Sexual Partners (last 3 years) - NAME:** | **Contact Information (Include phone number, physical address, other contact modalities)** | **Testing Modality**  | **Infections** |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs  |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs |
| **List of injection partners (last 3 years) - NAME:** | **Contact Information (Include phone number, physical address, other contact modalities)** | **Testing Modality** | **Infections** |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs |
|  |  | ☐ Provider-assisted partner services☐ Patient-led partner services☐ Self-test kit distribution☐ Referral for clinic testing | ☐ HIV ☐ Hep B☐ Hep C☐ Syphilis☐ Other STIs |

**Section B – Social Network Testing Services**

|  |  |  |  |
| --- | --- | --- | --- |
| Does the patient have social contacts who may need testing? | ☐ Yes ☐ NoIf yes, please fill out “social contacts” below |  |  |
| **List of Social Contacts – NAME:**  | **Contact Information (include phone number, physical address, other contact modalities):** | **Testing Modality** | **Infections** |
|  |  | ☐ Self-test kit distribution☐ Coupon-based referral☐ Other | ☐ HIV ☐ Syphilis☐ Other STIs |
|  |  | ☐ Self-test kit distribution☐ Coupon-based referral☐ Other | ☐ HIV ☐ Syphilis☐ Other STIs |
|  |  | ☐ Self-test kit distribution☐ Coupon-based referral☐ Other | ☐ HIV ☐ Syphilis☐ Other STIs |

**Section C – Family & Household Testing Services**

|  |  |  |  |
| --- | --- | --- | --- |
| Does the patient have family/household members, including any children in the household with unknown status? | ☐ Yes ☐ No If yes, please fill out “Family/Household Members” below |  |  |
| **List of Family/Household Members – NAME:**  | **Contact Information (include phone number, physical address, other contact modalities):** | **Testing Modality** |  |
|  |  | ☐ Testing in the home☐ Referral for clinic testing☐ HIV self-test kit distribution | ☐ HIV ☐ Hep B |
|  |  | ☐ Testing in the home☐ Referral for clinic testing☐ HIV self-test kit distribution | ☐ HIV ☐ Hep B |
|  |  | ☐ Testing in the home☐ Referral for clinic testing☐ HIV self-test kit distribution | ☐ HIV ☐ Hep B |