

HEP C/HIV Screening Tool

Individual's Name: _____

Date of Screen: _____

- (1) Were you born between the years 1945 and 1965?
 ___yes ___no

- (2) Have you received a clotting factor produced before 1987?
 ___yes ___no

- (3) Have you been on hemodialysis?
 ___yes ___no

- (4) Have you been diagnosed with HIV?
 ___yes ___no

- (5) Have you previously received a blood transfusion or organ transplant?
 ___yes ___no

- (6) Have you ever been an injection drug user?
 ___yes ___no

- (7) Have you engaged in unprotected sexual activities and/or sharing of needles?
 ___yes ___no

Individual is considered high risk for HEP C/HIV if he/she responds with a "yes" to any of the above questions and a referral to the County Public Health clinic is recommended.

The Drug and Alcohol Provider has explained to me the results of this screening tool.

If "at risk":

I do / do not request a referral to the Health Clinic.

Individuals Signature

Date/Time Referral was made to the Health Clinic: _____

Counselors signature: _____