# TREATMENT DAY FORM

**QUESTION IN BOLD ITALICS ARE TO BE ASKED TO STUDENT AND NOT RECORDED**

| | | |
|---|---|---|
| School Name: | Today's Date: | Interviewer : |
| Positive for:______________________________________________________<br>[ ] Negative<br>[ ] Retesting | | • ***What do you think about testing positive?***<br>• ***It sounds to me like you're feeling… Is that right?***<br>• ***What do you know already about how you get STDs? What do you already know about getting HIV?***<br>• ***That's right. Something you might not know is…*** |

## DEMOGRAPHICS AND CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Student's First Name: | | Middle: | Last: | | |
| Student's Preferred Name: | | | Gender Identity | | |
| Phone (Cell): | Email Address: | Preferred Method of Contact: | Birth date: | Age: | Sex-at-Birth: |
| Address: [Address/ P.O Box, City, ST ZIP Code] | | | | | |
| Time at Address: | | Live with: | | | |
| Emergency Contact: | | | | | |

## MEDICAL/HEALTH HISTORY

| | | | |
|---|---|---|---|
| Primary Care Doctor:<br>Yes [ ] No [ ] Not Sure [ ] | Name of Doctor or Clinic: | Medications: | Allergies: |

Pregnancy: Yes [ ] No [ ] Last Menstrual Cycle: _______________________

| | |
|---|---|
| Birth Control: Yes [ ] No [ ]<br>[ ] pill [ ] patch [ ] male condom [ ] Depo<br>[ ] Implanon [ ] vaginal ring [ ] IUD [ ] Other:__________________ | Have you ever been diagnosed with an STD before?<br>[ ] Yes : _____________________<br>[ ] No |

| | | | |
|---|---|---|---|
| Do you want to be tested for HIV today?<br>[ ] Yes[ ] No<br>Where is your last period class today?<br>_________________________________ | Do you use alcohol?<br>[ ] Yes [ ] No<br>How often: | Do you use drugs?<br>[ ] Yes [ ] No<br>Which drugs:<br>How often: | • ***Can you tell me about the last time you had sex while under the influence of alcohol, weed, or other substances?*** |

## STD DIAGNOSIS INFORMATION

Medications Given:

[ ] Azithromycin 1gm p.o. in a single dose Lot#/Exp. Date:

[ ] Cefixime 400mg p.o. in a single dose Lot#/Exp. Date:

________________________________________________

**Provider Signature** **Date**

| | |
|---|---|
| Symptoms: [ ] None [ ] Discharge [ ] Dysuria<br>[ ] Odor [ ] Discomfort/Itching [ ] Abnormal bleeding | Location: [ ] Urethra [ ] Vagina [ ] Anus<br>Duration: _____________________ |

Did you call the Dr. B line for your test results? [ ] Yes [ ] No

Why did you get tested for an STD?

[ ] I had symptoms I recognized [ ] I wanted to make sure I was STD free

[ ] My friends were doing it [ ] The education session convinced me

[ ] My partner was infected [ ] Don't know

[ ] Other: __________________________________________________________

## PARTNER SERVICES

- ***How do you feel about using condoms when having sex with new partners?***
- ***Can you tell me about the last time you asked a partner to use a condom?***
- ***Can you tell me about the thoughts you were having the last time you decided to have sex without a condom?***
- ***What has helped you to talk to your partner about using a condom (or other difficult issues) in the past***

Sex Partners:
[ ] M [ ] F [ ] Both [ ]Trans: MtF [ ]Trans: FtM

Number of Sex Partners in Last Year: ____ Men ______ Women
Number of Lifetime Partners: ____ Men ______Women

What types of sex do you have?
[ ] Vaginal [ ] Anal [ ] Oral [ ] Other

Do you have a steady partner? [ ] Yes [ ] No
Do you have unprotected sex? [ ] Yes [ ] No

Do you use condoms:
[ ] Always [ ] Sometimes [ ] Never

Where do you get free condoms at school?
[ ] Student Health Center [ ] School nurse
[ ] Student Wrap MC [ ] Adult Wrap MC
[ ] Coach [ ] Not from school
[ ] Other: ______________________________

| PARTNER 1 | | | | PARTNER 2 | | | |
|---|---|---|---|---|---|---|---|
| Name: | | Nickname: | | Name: | | Nickname: | |
| Age / DOB: | | School: | | Age / DOB: | | School: | |
| Address: | | | | Address: | | | |
| Phone/Cell: | | | | Phone/Cell: | | | |
| School Attended: | | | | School Attended: | | | |
| Description: | | | | Description: | | | |
| Complexion: | Hair: | Size/Build: | Height: | Complexion: | Hair: | Size/Build: | Height: |
| First had sex: | | Last had sex: | | First had sex: | | Last had sex: | |

Did you meet your partner through social media or hook up apps?
[ ] Yes [ ] No

Which social media platforms or apps do you use to meet your partners?
[ ] Facebook [ ] Instagram [ ] Twitter [ ] Other
[ ] Grindr [ ] Tinder [ ] Kik [ ] Craigslist

Where do you meet your sex partners?

Where do you have sex?

Do you have sex when traveling?

Do you have sex for money, drugs, food, or housing?

- ***How likely do you think you are to talk to your partner about using condoms the next time you have sex, on a scale of 1-10 where 1 is definitely will not and 10 is definitely will.***
- ***That's great. Why did you choose a (5) instead of a (4) or a (6)?***
- ***What would have to change for you to go from a (5) to a (7)?***
- ***What would make it easier for those things to happen?***
- ***It's okay to start by making small changes. What's one thing you think you could do to make it easier to use a condom the next time you have sex?***
- ***The next time you're in that situation, what could you tell yourself that would help you to remember why you want to make the safer decision to use a condom?***

Where do you plan to get retested in 3 months?
[ ] Student-Based Health Center [ ] My own doctor
[ ] Sasha Bruce Youthwork [ ] D.C. Health and Wellness Center
[ ] Unity Healthcare [ ] WW Youth Center
[ ] Latin American Youth Center [ ] Not Sure
[ ] CNMC [ ] I probably won't get tested again

- ***What situations would make it hard for you to get tested again in 3 months?***
- ***What situations do you think would make it hard for you to use a condom?***
- ***What can you do to avoid those situations?***
- ***If you find yourself in those situations, what could you do to remind yourself that you want to use a condom/get tested again?***

**Referrals needed**
Contraception [ ] Yes [ ] No
Emergency Contraception ( unprotected vaginal sex in last 96 hours) [ ] Yes [ ] No
Options counseling/pregnancy referral [ ] Yes [ ] No