

Community-Based Testing Assessment Form

Today's date: ____/____/____

City or County of Residence: _____ **State:** _____ **Zip:** _____

Age: _____

Gender: Male Female Transgender (Male to Female) Transgender (Female to Male)

Race: White Pacific Islander/Hawaiian Asian
 Black American Indian/Alaska Native Other _____

Ethnicity: Hispanic or Latino Non-Hispanic

Sexual health history in past 12 months
(Check all that apply):
 Sex with male More than 1 sex partner HIV positive
 Sex with female Chlamydia or gonorrhea diagnosis Jail/prison
 Injection drug use Sex with someone who had syphilis Pregnancy
 Illicit drug use Exchanged sex for money or drugs
 Met sex partner through internet or mobile app
 Sex with anyone you would not be able to contact again

Symptoms in past 12 months
(Check all that apply):
 Sore(s) in mouth/lips Condyloma lata (wart-like lesions on genitals)
 Generalized body rash Palmar/plantar rash (hands/ bottoms of feet)
 Genital sore/ lesion Sudden hair loss Swollen lymph nodes (groin)

Have you ever been diagnosed with syphilis?
 Yes (If yes, you are not a candidate for the rapid syphilis test) No Not Sure

For Office Use Only:

Rapid Syphilis Test results: Positive (complete Epi-1 & attach) Negative Invalid

Rectal CT/GC: Specimen collected (MSM only) Did not receive test

Last Name: _____ **Date of Birth:** ____/____/____

Site ID* of agency completing assessment: _____
*same ID used for HIV Testing

Mail or fax assessment forms to:
(804) 864-7970
Attention: DDP SODA

Virginia Department of Health
Division of Disease Prevention, 2nd floor
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