

## ADVANCED HEALTH SCREENING

### HIV Risk Factors

- Shares needles for injecting drugs, tattoos, or lay health injections
- Shares works or cocaine straws
- Health care or accidental exposure – injury with used needle, etc.
- Recipient of a transfusion or clotting factors before 1987
- Sex with more than one partner in the past 6 months or since last HIV test
- Sex without a condom
- Sex in exchange for drugs or money or while using drugs
- Current or previous sexually transmitted infection
- Victim of sexual assault
- Sex with HIV positive person or person with risk factors above
- Are you or your partner a man who has sex with other men?

If you have any of these risk factors and have not been tested since 3 months after your last exposure, we recommend you have an HIV test. Are you interested in being tested?    ? Yes            ? No

- *If yes, perform HIV Counseling/Testing/Referral, or refer to testing site.*
- *Consider screening for syphilis, GC, and Chlamydia.*

**Diabetes symptoms:** Excessive thirst, frequent urination, increased appetite with weight loss, blurred vision, and excessive fatigue: ? No    ? Yes            *If yes, test or refer*

**Diabetes risk:**            *consider test for the following 3 groups*

Glucose \_\_\_\_\_

Last food or drink \_\_\_\_\_

1. Everyone age 45 and above
2. Everyone of low risk ethnicity (Caucasian) who has 2 additional risk factors
3. Everyone of a high risk ethnicity (African-American, Hispanic-American, Native American, Pacific American, Pacific Islander) who has one additional risk factor

### Diabetes Risk factors:

- First-degree relative with diabetes
- Overweight (with Body Mass Index (BMI) over 25)
- Not physically active
- Previously identified glucose intolerance or borderline diabetes
- High blood pressure or high cholesterol
- History of heart disease, stroke, or circulation problems
- Acanthosis nigricans (dark skin around neck and under arms)
- History of gestational diabetes, baby over 9 pounds, or polycystic ovarian syndrome

### Heart Health

**BP** \_\_\_\_\_ (< 120/80 normal; 120/80 – 139/89 borderline; = 140/90 or on medication - high)

**Height** \_\_\_\_\_    **Weight** \_\_\_\_\_    **BMI** \_\_\_\_\_    **BMI goal range:** \_\_\_\_\_  
(BMI 19-24)

**Waist Circumference** \_\_\_\_\_ (high risk: = 40 inches for men, = 35 inches for women)

**Exercise:** < 1.5 hours / week \_\_\_\_\_    1.5-3.0 hours / week \_\_\_\_\_    = 3 hours / week \_\_\_\_\_

**Smoker:**            ? Yes            ? No

*BP abnormal: lifestyle counseling*

*Lack of exercise: increase activity counseling*

*BMI or waist circumference abnormal: weight loss counseling*

*Smoker: smoking cessation counseling*

## ADVANCED HEALTH SCREENING

### Domestic Violence

Do you ever feel unsafe at home? \_\_\_\_\_  
Has anyone at home hit you or tried to injure you in any way? \_\_\_\_\_  
Have you ever been abused physically, emotionally, or sexually? \_\_\_\_\_

### Human Trafficking

What type of work do you do? \_\_\_\_\_  
Are you being paid? \_\_\_\_\_  
Can you leave your job if you want to? \_\_\_\_\_  
Can you come and go as you please? \_\_\_\_\_  
Have you or your family been threatened? \_\_\_\_\_  
What are your working and living conditions like? \_\_\_\_\_  
Where do you sleep and eat? \_\_\_\_\_  
Do you have to ask permission to eat, sleep, or go to the bathroom? \_\_\_\_\_  
Are there locks on your doors or windows so you cannot get out? \_\_\_\_\_  
Has your identification card or documentation been taken from you? \_\_\_\_\_

*If concern and client agrees, call trafficking Information and Referral Hotline – 1-888-373-7888*

### Substance Abuse Advanced Assessment – if screening question positive

#### **Quantity Assessment**

On average, how many days per week do you drink? \_\_\_\_\_  
How much do you drink on days when you drink? \_\_\_\_\_  
What is the maximum number of drinks you had on any given occasion last month? \_\_\_\_\_

*At risk: Men > 14 drinks / week or > 4 drinks per occasion;*

*Women > 7 drinks per week or > 3 drinks per occasion*

#### **CAGE**

Have you ever felt that you should **Cut Down** on your drinking?      ? Yes   ? No  
Have people **Annoyed** you by criticizing your drinking?      ? Yes   ? No  
Have you ever felt bad or **Guilty** about your drinking?      ? Yes   ? No  
Have you ever had a drink first thing in the morning to steady  
your nerves or get rid of a hangover? (**Eye opener**)      ? Yes   ? No

*Positive: 2 yes answers. If positive, refer for further assessment and treatment.*

### Substance Abuse Response if at risk:

- ? Advise women who drink to abstain if they become pregnant.
- ? Advise everyone not to drink and drive.
- ? State: I am concerned about your drinking and want you to cut down.
- ? Agree on a drinking goal – harm reduction, safe drinking \_\_\_\_\_
  - Men < 14 drinks / week or < 4 drinks per occasion;
  - Women < 7 drinks per week or < 3 drinks per occasion.
- ? Refer \_\_\_\_\_

## ADVANCED HEALTH SCREENING

### Depression Screening

During the past month, have you often been bothered by feeling down, depressed, or hopeless? \_\_\_\_\_

During the last month, have you often been bothered by little interest or pleasure in doing things? \_\_\_\_\_

Have these symptoms made it hard for you to do your work, take care of things at home, or get along with people? \_\_\_\_\_

Have you thought about hurting or killing yourself? \_\_\_\_\_

*If yes to suicide screen, contract for safety and refer ASAP* \_\_\_\_\_

*If yes to any, refer* \_\_\_\_\_

### Depression Diagnostic Criteria

Depression = 5 or more of the above, must include depressed mood or anhedonia, during the same 2-week period, causing significant distress or impairment:

	Depressed mood most of the day, nearly every day
	Markedly diminished interest or pleasure in almost all activities (anhedonia)
	Substantial unintentional weight loss or gain
	Insomnia or hypersomnia nearly every day, including early morning wakening
	Psychomotor agitation or retardation nearly every day
	Fatigue or lack of energy nearly every day
	Feelings of worthlessness or excessive guilt nearly every day
	Diminished ability to think or concentrate nearly every day
	Recurrent thoughts of death or suicide – if yes, contract for safety and refer
	If a parent, thought of harming their children – if yes, refer immediately
	<b>Total</b>

### Bipolar Screening

Have you ever had 4 continuous days when you were feeling so good, high, excited, or “hyper” that other people thought you were not your normal self, or you got into trouble? \_\_\_\_\_

Have you experienced 4 continuous days when you were so irritable that you found yourself shouting at people or starting fights or arguments? \_\_\_\_\_

### Obsessive Compulsive Disorder Screening

Do you have repetitive thoughts that make you anxious and that you cannot get rid of no matter how hard you try? \_\_\_\_\_

Do you keep things extremely clean or wash your hands frequently? \_\_\_\_\_

Do you check things to excess? \_\_\_\_\_