

PEMS Data Collection Forms for Comprehensive Risk and Counseling Services (CRCS) and  
Health Education/Risk Reduction Prevention Interventions

<i><b>Intervention</b></i>	<i><b>Client-Level Data</b></i>				<i><b>Aggregate Data</b></i>		<i><b>Referral</b></i>
	<b>G1</b>	<b>G2</b>	<b>H</b>	<b>I</b>	<b>AG</b>	<b>HC</b>	<b>X7</b>
<b>B.A.R.T.</b> -intervention delivered to a group- 8 sessions	X	X	X	O			X
<b>CRCS</b> -individual sessions	X	X	X	O			X
<b>Healthy Relationships</b> -intervention delivered to a group	X	X	X	O			X
<b>Holistic Health Recovery</b> -intervention delivered to a group	X	X	X	O			X
<b>Many Men, Many Voices</b> -intervention delivered to a group	X	X	X	O			X
<b>Mpowerment</b> -M-Groups; 1 session	X	X	X	O			X
-Formal Outreach					X		
-Publicity Campaign for Recruitment						X	
<b>POL</b> -Opinion Leader brief contact outreach					X		
<b>PROMISE</b> -Peer dissemination of role model stories					X		
<b>RAPP</b> -Safer Sex Gatherings (skills building; 1 session)	X	X	X	O			X
-Peer dissemination of role model stories					X		*
-Stage-Based Outreach	X	X	X				X
-Small Group Presentations (option 2-educational)					X		*
-Community Network						X	
<b>RESPECT</b> -intervention delivered to an individual- 2 sessions	X	X	X	O			X
<b>Safety Counts</b> -intervention delivered to a group	X	X	X	O			X
-intervention delivered to an individual –multiple sessions	X	X	X	O			X
<b>SISTA</b> -intervention delivered to a group	X	X	X	O			X
<b>Street Smart</b> -intervention delivered to a group (group-in sessions, different clients)	X	X	X	O			X
-intervention delivered to an individual-single session	X	X	X	O			X
<b>Together Learning Choices</b> -intervention delivered to a group (same clients)	X	X	X	O			X
-intervention delivered to a group (drop-in sessions, different clients)	X	X	X	O	X		X
<b>VOICES</b> -Single-session intervention delivered to a group	X	X	X	O			X

X = Required                      O = Optional

\* It is expected that referrals with tracking and follow-up will not be made from these intervention; rather, there is likely to be information provided about the availability of various services. These situations will only be considered

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“referrals” if they have the appropriate data collected (e.g. the minimal demographic information) and if referral tracking is done to learn about the outcome of the referral.

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**G1: Demographic Information**

Local Client Key (PEMS Client ID)							
Name				Birthdate			
First (Initial)	Last (Initial)	Gender (M, F, T, O)	Race/Ethnicity (B, W, H, O)	Month (0-1)	Month (0-2)	Year (0-9)	Year (0-9)
		<i>M=Male</i> <i>F=Female</i> <i>T=Transgender</i> <i>O=Other</i>	<i>B=Black</i> <i>W=White</i> <i>H=Hispanic</i> <i>O=Other</i>				

<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Decline to answer	<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Don't Know <input type="checkbox"/> Decline to answer	<b>Place of Birth:</b> _____	
		<b>English Speaking:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<b>In what state do you currently live?</b> _____
		<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole/French <input type="checkbox"/> Other (specify) _____	
<b>Sex at Birth:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Current Gender Identity:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender, Female to Male <input type="checkbox"/> Transgender, Male to Female		

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**G2: Risk Profile**

<p><b>Have you had a previous HIV test?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p> <p><input type="checkbox"/> Decline to answer</p>	<p><b>If yes, what was the result of the most recent HIV test?</b></p> <p><input type="checkbox"/> Positive</p> <p><input type="checkbox"/> Negative</p> <p><input type="checkbox"/> Indeterminate</p> <p><input type="checkbox"/> Decline to answer</p> <p><b>If yes, what is the date of last HIV test?</b>          ___ / ___ (MM/YYYY)</p>
<b>Currently...</b>	
<p><b>If you are HIV positive, are you receiving antiretroviral therapy or prophylaxis for an opportunistic infection?</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Don't Know                      <input type="checkbox"/> Decline to answer</p>	
<p><b>If you are a female, are you pregnant?</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Don't Know                      <input type="checkbox"/> Decline to answer</p>	
<p><b>If you are pregnant, are you in prenatal care?</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Don't Know                      <input type="checkbox"/> Decline to answer</p>	
<b>In the past 12 months...</b>	
<p>Have you been incarcerated, imprisoned, or in jail?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Decline to answer</p>	
<p>Have you received money or items of value from engaging in sexual intercourse?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Decline to answer</p>	
<p>Have you met sex partners on the Internet?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Decline to answer</p>	
<p><b>Have you had Chlamydia, gonorrhea, syphilis?</b></p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No                      <input type="checkbox"/> Don't Know                      <input type="checkbox"/> Decline to answer</p>	
<b>Client Risk Factors</b>	
<p><b>What potential risks have you had for getting HIV from or passing HIV to another person in the past 12 months?</b></p> <p><input type="checkbox"/> Injection drug use</p> <p><input type="checkbox"/> Anal and/or vaginal sex with male partner(s)</p> <p><input type="checkbox"/> Anal and/or vaginal sex with female partner(s)</p> <p><input type="checkbox"/> Anal and/or vaginal sex with transgender partner(s)</p> <p><input type="checkbox"/> Share drug injection equipment</p> <p><input type="checkbox"/> Oral sex with male partner(s)</p> <p><input type="checkbox"/> Oral sex with female partner(s)</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> No risk identified</p> <p><input type="checkbox"/> Decline to answer</p>	

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**G2: Risk Profile (continued)**

<p><b>What other potential risks have you had with sex partners in the past 12 months?</b> (Check all the apply)</p>				
<p>You had the following potential risks <b>with male</b> partners(s)...</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Exchanged sex for drugs, money, or items of value</li> <li><input type="checkbox"/> Had sex while intoxicated and/or high on drugs or alcohol</li> <li><input type="checkbox"/> Partner(s) is an injection drug user</li> <li><input type="checkbox"/> Partner(s) is HIV positive</li> <li><input type="checkbox"/> Did not know HIV status of partner(s)</li> <li><input type="checkbox"/> Partner(s) exchanged sex for drugs/money</li> <li><input type="checkbox"/> Partner(s) had sex with other men</li> <li><input type="checkbox"/> Partner(s) was anonymous</li> <li><input type="checkbox"/> Partner(s) has hemophilia or is a transfusion/transplant recipient</li> <li><input type="checkbox"/> Client had sex without using a condom</li> <li><input type="checkbox"/> No additional risk information specified</li> <li><input type="checkbox"/> Decline to answer</li> </ul>	<p>You had the following potential risks <b>with female</b> partners(s)...</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Exchanged sex for drugs, money, or items of value</li> <li><input type="checkbox"/> Had sex while intoxicated and/or high on drugs or alcohol</li> <li><input type="checkbox"/> Partner(s) is an injection drug user</li> <li><input type="checkbox"/> Partner(s) is HIV positive</li> <li><input type="checkbox"/> Did not know HIV status of partner(s)</li> <li><input type="checkbox"/> Partner(s) exchanged sex for drugs/money</li> <li><input type="checkbox"/> Partner(s) was anonymous</li> <li><input type="checkbox"/> Partner(s) has hemophilia or is a transfusion/transplant recipient</li> <li><input type="checkbox"/> Client had sex without using a condom</li> <li><input type="checkbox"/> No additional risk information specified</li> <li><input type="checkbox"/> Decline to answer</li> </ul>	<p>You had the following potential risks <b>with transgender</b> partners(s)...</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Exchanged sex for drugs, money, or items of value</li> <li><input type="checkbox"/> Had sex while intoxicated and/or high on drugs or alcohol</li> <li><input type="checkbox"/> Partner(s) is an injection drug user</li> <li><input type="checkbox"/> Partner(s) is HIV positive</li> <li><input type="checkbox"/> Did not know HIV status of partner(s)</li> <li><input type="checkbox"/> Partner(s) exchanged sex for drugs/money</li> <li><input type="checkbox"/> Partner(s) had sex with other men</li> <li><input type="checkbox"/> Partner(s) was anonymous</li> <li><input type="checkbox"/> Partner(s) has hemophilia or is a transfusion/transplant recipient</li> <li><input type="checkbox"/> Client had sex without using a condom</li> <li><input type="checkbox"/> No additional risk information specified</li> <li><input type="checkbox"/> Decline to answer</li> </ul>		
<p><b>If injection drug use was previously identified as a potential risk factor, what injection drugs were used?</b> (Check all that apply)</p>				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heroin and cocaine together</li> <li><input type="checkbox"/> Heroin alone</li> <li><input type="checkbox"/> Amphetamines, speed, crystal, meth, and ice</li> <li><input type="checkbox"/> Cocaine alone</li> <li><input type="checkbox"/> Crack</li> </ul> </td> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> <li><input type="checkbox"/> Other narcotics</li> <li><input type="checkbox"/> Hormones</li> <li><input type="checkbox"/> Steroids</li> <li><input type="checkbox"/> Botox</li> <li><input type="checkbox"/> Other Medical Substances</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li><input type="checkbox"/> Heroin and cocaine together</li> <li><input type="checkbox"/> Heroin alone</li> <li><input type="checkbox"/> Amphetamines, speed, crystal, meth, and ice</li> <li><input type="checkbox"/> Cocaine alone</li> <li><input type="checkbox"/> Crack</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Other narcotics</li> <li><input type="checkbox"/> Hormones</li> <li><input type="checkbox"/> Steroids</li> <li><input type="checkbox"/> Botox</li> <li><input type="checkbox"/> Other Medical Substances</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Heroin and cocaine together</li> <li><input type="checkbox"/> Heroin alone</li> <li><input type="checkbox"/> Amphetamines, speed, crystal, meth, and ice</li> <li><input type="checkbox"/> Cocaine alone</li> <li><input type="checkbox"/> Crack</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Other narcotics</li> <li><input type="checkbox"/> Hormones</li> <li><input type="checkbox"/> Steroids</li> <li><input type="checkbox"/> Botox</li> <li><input type="checkbox"/> Other Medical Substances</li> </ul>			

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**H: Intervention Details**

Session Template Name:			
<b>Year:</b>		<b>Program Name:</b>	
<b>Program Model Name:</b>		<b>Intervention Name:</b>	
<b>Cycle:</b>	<b>Session:</b>	<b>Duration (in mins.):</b>	
<b>Worker:</b>		<b>Site:</b>	
<b>Unit of Delivery:</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Large Group	<input type="checkbox"/> Couple <input type="checkbox"/> Community	<input type="checkbox"/> Small Group (2-12)
<b>Delivery Method:</b>	<input type="checkbox"/> In Person <input type="checkbox"/> Printed: Magazines/Newspapers <input type="checkbox"/> Telephone	<input type="checkbox"/> Internet <input type="checkbox"/> Printed: Pamphlets/Brochures <input type="checkbox"/> Television	<input type="checkbox"/> Printed Materials <input type="checkbox"/> Radio Posters/Billboards <input type="checkbox"/> Video <input type="checkbox"/> Other (specify):
<b>Activity(s):</b> (check all that apply)	<input type="checkbox"/> HIV Testing <input type="checkbox"/> Elicit Partners	<input type="checkbox"/> Referral <input type="checkbox"/> Post Intervention Follow-up	<input type="checkbox"/> Personalized Risk Assessment <input type="checkbox"/> HIV Testing History Survey
<b>Information:</b> <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Abstinence/Postpone Sex <input type="checkbox"/> Other STDs <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Availability of HIV Counseling & Testing <input type="checkbox"/> Availability of Partner Notification <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of Social Services <input type="checkbox"/> Availability of Medical Services <input type="checkbox"/> Sexual Risk Reduction <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> IDU Risk Free Behavior <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> HIV Testing <input type="checkbox"/> Partner Notification <input type="checkbox"/> HIV Med. Therapy Adherence <input type="checkbox"/> Drug & Alcohol Use Prevention <input type="checkbox"/> Sexual Health <input type="checkbox"/> TB Testing <input type="checkbox"/> Other	<b>Demonstration:</b> <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> Negotiation/ Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Partner Notification <input type="checkbox"/> Other <b>Practice:</b> <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Partner Notification <input type="checkbox"/> Other <b>Other Testing:</b> <input type="checkbox"/> Pregnancy <input type="checkbox"/> STD <input type="checkbox"/> Viral Hepatitis	<b>Discussion:</b> <input type="checkbox"/> Sexual Risk Reduction <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> HIV Testing <input type="checkbox"/> Other STDs <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Partner Notification <input type="checkbox"/> HIV Med Therapy Adherence <input type="checkbox"/> Abstinence/ Postpone Sex <input type="checkbox"/> IDU Risk-Free Behavior <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of HIV Counseling and Testing <input type="checkbox"/> Availability of Partner Services <input type="checkbox"/> Availability of Social Services <input type="checkbox"/> Availability of Medical Services <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Drug & Alcohol Use Prevention <input type="checkbox"/> Sexual Health <input type="checkbox"/> TB Testing <input type="checkbox"/> Other	
<b>Distribution:</b>	<input type="checkbox"/> Male Condoms <input type="checkbox"/> Education Materials	<input type="checkbox"/> Female Condoms <input type="checkbox"/> Safer Injection/Bleach Kits	<input type="checkbox"/> Safe Sex Kits <input type="checkbox"/> Referral Lists
<input type="checkbox"/> Role Model Stories	<input type="checkbox"/> Other		

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**I: Behavioral Details**

What potential risks have you had for getting HIV from or passing HIV to another person in the past 12 months?

<input type="checkbox"/> Injection drug use	<input type="checkbox"/> Sex with a Male
<input type="checkbox"/> Sex with a Transgender	<input type="checkbox"/> No risk identified
<input type="checkbox"/> Sex with a Female	<input type="checkbox"/> Decline to answer
<input type="checkbox"/> Other (specify): _____	

**Enter the number of sexual partners in the past 12 months.**

Number of sexual partners	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of sex partners with unknown HIV status	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of anonymous sex partners of unknown HIV status	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know

**Enter the number of sexual events in the past 12 months.**

Total numbers of sex events	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of sex events with unknown HIV status partner	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of unprotected sex events	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of unprotected sex events with an unknown HIV status partner (TOTAL)	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
If applicable, number of unprotected sex events with an unknown HIV status partner (MALE)	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
If applicable, number of unprotected sex events with an unknown HIV status partner (FEMALE)	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
If applicable, number of unprotected sex events with an unknown HIV status partner (TRANSGENDER)	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of unprotected sex events with a partner who is an injection drug user	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of unprotected sex events with a partner who exchanged sex for drugs or money	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of unprotected sex events while intoxicated and/or high on non-injection drugs	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know

**Enter the number of needle sharing events, if you are an IDU, in the past 12 months**

Number of needle sharing events	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know
Number of injection drug events with an unknown HIV status partner (TOTAL)	___ Number	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Don't Know

Have you had sex while high on non-injection drugs? If yes, what drugs were used but not injected before or during unprotected anal or vaginal intercourse?

<input type="checkbox"/> Amphetamines, Speed, Crystals, Meth, Ice	<input type="checkbox"/> Pain Killers	<input type="checkbox"/> Poppers
<input type="checkbox"/> Crack	<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Marijuana
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Declined to Answer
<input type="checkbox"/> Downers	<input type="checkbox"/> Club Drugs (GHB, etc)	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> Heroin	<input type="checkbox"/> Other (specify)_____

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**AG: HE/RR and Outreach Intervention Details**

<b>Year:</b>			<b>Program Name:</b>		
<b>Program Model Name:</b>			<b>Intervention Name:</b>		
<b>Session Date:</b>		<b>Session Number:</b>		<b>Duration (in mins.):</b>	
<b>Number of Client Contacts:</b>					
<b>Site:</b>			<b>Worker:</b>		
<i>Enter the Number or Percentage of Participants for all of the following Client Characteristics</i>					
<b>Primary Risk</b>			<b>Gender</b>		
	Number	Percent		Number	Percent
MSM			Male		
IDU			Female		
MSM/IDU			Transgender MTF		
Sex Involving Transgender			Transgender FTM		
Heterosexual Contact			<b>Ethnicity</b>		
Other/Risk Identified			Hispanic or Latino		
<b>Age Group</b>			Not Hispanic or Latino		
Under 13			<b>Race</b>		
14-18			American Indian or Alaska Native		
19-24			Asian		
25-34			Black or African American		
35-44			Native Hawaiian or Alaska Native		
45 and older			White		
<b>HIV Status</b>					
HIV Negative					
HIV Positive					
Unknown					
<b>Delivery Method:</b> <input type="checkbox"/> In Person <input type="checkbox"/> Internet <input type="checkbox"/> Printed Materials					
<input type="checkbox"/> Printed: <input type="checkbox"/> Printed: <input type="checkbox"/> Printed: <input type="checkbox"/> Radio					
Magazines/Newspapers                 Pamphlets/Brochures                 Posters/Billboards					
<input type="checkbox"/> Telephone <input type="checkbox"/> Television <input type="checkbox"/> Video <input type="checkbox"/> Other (specify): _____					

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**AG: HE/RR and Outreach Intervention Details (continued)**

<b>Activity(s):</b> (check all that apply)						
<input type="checkbox"/> Elicit Partners	<input type="checkbox"/> HIV Testing	<input type="checkbox"/> Referral	<input type="checkbox"/> Personalized Risk Assessment			
	<input type="checkbox"/> Post Intervention Follow-up	<input type="checkbox"/> Post Intervention Booster Session	<input type="checkbox"/> HIV Testing History Survey			
<table border="1"> <tr> <td style="vertical-align: top;"> <b>Information:</b>  <input type="checkbox"/> HIV/AIDS Transmission  <input type="checkbox"/> Abstinence/Postpone Sex  <input type="checkbox"/> Other STDs  <input type="checkbox"/> Viral Hepatitis  <input type="checkbox"/> Availability of HIV Counseling &amp; Testing  <input type="checkbox"/> Availability of Partner Notification  <input type="checkbox"/> Living with HIV/AIDS  <input type="checkbox"/> Availability of Medical Services  <input type="checkbox"/> Sexual Risk Reduction  <input type="checkbox"/> IDU Risk Reduction  <input type="checkbox"/> IDU Risk Free Behavior  <input type="checkbox"/> Condom/Barrier Use  <input type="checkbox"/> Negotiation/Communication  <input type="checkbox"/> Decision Making  <input type="checkbox"/> Disclosure of HIV Status  <input type="checkbox"/> Providing Prevention Services  <input type="checkbox"/> HIV Testing  <input type="checkbox"/> Partner Notification  <input type="checkbox"/> HIV Med. Therapy Adherence  <input type="checkbox"/> Drug &amp; Alcohol Use Prevention  <input type="checkbox"/> Sexual Health  <input type="checkbox"/> TB Testing  <input type="checkbox"/> Other                 </td> <td style="vertical-align: top;"> <b>Demonstration:</b>  <input type="checkbox"/> Condom/Barrier Use  <input type="checkbox"/> IDU Risk Reduction  <input type="checkbox"/> Negotiation/Communication  <input type="checkbox"/> Decision Making  <input type="checkbox"/> Disclosure of HIV Status  <input type="checkbox"/> Providing Prevention Services  <input type="checkbox"/> Partner Notification  <input type="checkbox"/> Other   <b>Practice:</b>  <input type="checkbox"/> Condom/Barrier Use  <input type="checkbox"/> IDU Risk Reduction  <input type="checkbox"/> Negotiation/Communication  <input type="checkbox"/> Decision Making  <input type="checkbox"/> Disclosure of HIV Status  <input type="checkbox"/> Providing Prevention Services  <input type="checkbox"/> Partner Notification  <input type="checkbox"/> Other   <b>Other Testing:</b>  <input type="checkbox"/> Pregnancy  <input type="checkbox"/> STD  <input type="checkbox"/> Viral Hepatitis                 </td> <td style="vertical-align: top;"> <b>Discussion:</b>  <input type="checkbox"/> Sexual Risk Reduction  <input type="checkbox"/> IDU Risk Reduction  <input type="checkbox"/> HIV Testing  <input type="checkbox"/> Other STDs  <input type="checkbox"/> Disclosure of HIV Status  <input type="checkbox"/> Partner Notification  <input type="checkbox"/> HIV Med Therapy Adherence  <input type="checkbox"/> Abstinence/Postpone Sex  <input type="checkbox"/> IDU Risk-Free Behavior  <input type="checkbox"/> HIV/AIDS Transmission  <input type="checkbox"/> Viral Hepatitis  <input type="checkbox"/> Living with HIV/AIDS  <input type="checkbox"/> Availability of HIV Counseling and Testing  <input type="checkbox"/> Availability of Partner Services  <input type="checkbox"/> Availability of Social Services  <input type="checkbox"/> Availability of Medical Services  <input type="checkbox"/> Condom/Barrier Use  <input type="checkbox"/> Negotiation/Communication  <input type="checkbox"/> Decision Making  <input type="checkbox"/> Providing Prevention Services  <input type="checkbox"/> Drug &amp; Alcohol Use Prevention  <input type="checkbox"/> Sexual Health  <input type="checkbox"/> TB Testing  <input type="checkbox"/> Other                 </td> </tr> </table>				<b>Information:</b> <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Abstinence/Postpone Sex <input type="checkbox"/> Other STDs <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Availability of HIV Counseling & Testing <input type="checkbox"/> Availability of Partner Notification <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of Medical Services <input type="checkbox"/> Sexual Risk Reduction <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> IDU Risk Free Behavior <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> HIV Testing <input type="checkbox"/> Partner Notification <input type="checkbox"/> HIV Med. 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<b>Distribution:</b>						
<input type="checkbox"/> Lubricants # _____	<input type="checkbox"/> Male Condoms # _____	<input type="checkbox"/> Female Condoms # _____	<input type="checkbox"/> Safe Sex Kits # _____			
<input type="checkbox"/> Role Model Stories # _____	<input type="checkbox"/> Education Materials # _____	<input type="checkbox"/> Safer Injection/Bleach Kits # _____	<input type="checkbox"/> Referral Lists # _____			
	<input type="checkbox"/> Other # _____					

**Bold** indicates the variable is required

PEMS Data Collection Forms for Comprehensive Risk and Counseling Services (CRCS) and Health Education/Risk Reduction Prevention Interventions

Date Collected: \_\_\_ / \_\_\_ / \_\_\_\_\_

**HC: Health Communication/Public Information**

<b>Year:</b>		<b>Program Name:</b>	
<b>Program Model Name:</b>		<b>Intervention Name:</b>	
<b>Event Start Date:</b>		<b>Event End Date:</b>	
Key Message:			
<b>Delivery Method:</b>	<input type="checkbox"/> In Person	<input type="checkbox"/> Internet	<input type="checkbox"/> Printed Materials
<input type="checkbox"/> Printed: Magazines/Newspapers	<input type="checkbox"/> Printed: Pamphlets/Brochures	<input type="checkbox"/> Printed: Posters/Billboards	<input type="checkbox"/> Radio
<input type="checkbox"/> Telephone	<input type="checkbox"/> Television	<input type="checkbox"/> Video	<input type="checkbox"/> Other (specify): _____
<b>Information:</b> <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Other STDs <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Availability of HIV Counseling & Testing <input type="checkbox"/> Availability of Partner Notification <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of Social Services <input type="checkbox"/> Availability of Medical Services <input type="checkbox"/> Sexual Risk Reduction <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> IDU Risk Free Behavior <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> HIV Testing <input type="checkbox"/> Partner Notification <input type="checkbox"/> HIV Med. Therapy Adherence <input type="checkbox"/> Drug & Alcohol Use Prevention <input type="checkbox"/> Sexual Health <input type="checkbox"/> TB Testing <input type="checkbox"/> Other	<b>Demonstration:</b> <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Partner Notification <input type="checkbox"/> Other	<b>Discussion:</b> <input type="checkbox"/> Sexual Risk Reduction <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> HIV Testing <input type="checkbox"/> Other STDs <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Partner Notification <input type="checkbox"/> HIV Med Therapy Adherence <input type="checkbox"/> Abstinence/ Postpone Sex <input type="checkbox"/> IDU Risk-Free Behavior <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Viral Hepatitis <input type="checkbox"/> Living with HIV/AIDS <input type="checkbox"/> Availability of HIV Counseling and Testing <input type="checkbox"/> Availability of Partner Services <input type="checkbox"/> Availability of Social Services <input type="checkbox"/> Availability of Medical Services <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Drug & Alcohol Use Prevention <input type="checkbox"/> Sexual Health <input type="checkbox"/> TB Testing <input type="checkbox"/> Other	
<b>Practice:</b> <input type="checkbox"/> Condom/Barrier Use <input type="checkbox"/> IDU Risk Reduction <input type="checkbox"/> Negotiation/Communication <input type="checkbox"/> Decision Making <input type="checkbox"/> Disclosure of HIV Status <input type="checkbox"/> Providing Prevention Services <input type="checkbox"/> Partner Notification <input type="checkbox"/> Other	<b>Other Testing:</b> <input type="checkbox"/> Pregnancy <input type="checkbox"/> STD <input type="checkbox"/> Viral Hepatitis		

**Bold** indicates the variable is required

PEMS Data Collection Forms for Comprehensive Risk and Counseling Services (CRCS) and Health Education/Risk Reduction Prevention Interventions

Date Collected: \_\_\_ / \_\_\_ / \_\_\_\_\_

**X7: Referral**

Local Client Key (PEMS Client ID)							
Name				Birthdate			
First (Initial)	Last (Initial)	Gender (M, F, T, O)	Race/Ethnicity (B, W, H, O)	Month (0-1)	Month (0-2)	Year (0-9)	Year (0-9)
		M=Male F=Female T=Transgender O=Other	B=Black W=White H=Hispanic O=Other				

Intervention Name:			
<b>Referral Date:</b>			
<b>PEMS Generated Referral Code:</b>			
<b>Referral Type:</b>	<input type="checkbox"/> HIV Testing	<input type="checkbox"/> HIV Confirmatory Test	<input type="checkbox"/> HIV Prevention Counseling
<input type="checkbox"/> STD Screening and Treatment	<input type="checkbox"/> Viral Hepatitis Screening and Treatment	<input type="checkbox"/> TB Testing	<input type="checkbox"/> Syringe Exchange
<input type="checkbox"/> Reproductive Health Services	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> HIV Medical Care/Evaluation/Treatment	<input type="checkbox"/> IDU Risk Reduction Services
<input type="checkbox"/> Substance Abuse Services	<input type="checkbox"/> General Medical Care	<input type="checkbox"/> Partner Services	<input type="checkbox"/> Mental Health Services
<input type="checkbox"/> Comprehensive Risk Counseling Services	<input type="checkbox"/> Other Prevention Services	<input type="checkbox"/> Other Support Services	<input type="checkbox"/> Case Management
How is the referral verified?	<input type="checkbox"/> None	<input type="checkbox"/> Active Referral (direct linkage/access to a service provider)	
	<input type="checkbox"/> Passive Referral-Agency Verification (confirmation by an agency)	<input type="checkbox"/> Passive Referral-Client Confirmation (confirmation by the client that accessed the service)	
<b>Referral Outcome:</b>	<input type="checkbox"/> Pending	<input type="checkbox"/> Confirmed - Access Service	<input type="checkbox"/> Confirmed - Client did not Access Service (IF CHECKED, CONTINUE TO NEXT SECTION)
	<input type="checkbox"/> Lost to Follow-Up	<input type="checkbox"/> No Follow-Up	

**Bold** indicates the variable is required

PEMS Data Collection Forms for Comprehensive Risk and Counseling Services (CRCS) and Health Education/Risk Reduction Prevention Interventions

Date Collected: \_\_\_ / \_\_\_ / \_\_\_\_\_

**X7: Referral (continued)**

Why did the client not access the service?	<input type="checkbox"/> No Reason/Just Didn't Try	<input type="checkbox"/> No time/Too Busy/Put it off	<input type="checkbox"/> Did Not Like Agency Referred to
<input type="checkbox"/> Agency Hours Not Good	<input type="checkbox"/> Never Filled out Forms	<input type="checkbox"/> Not Enough Information on Availability of Service or Location	<input type="checkbox"/> No Transportation
<input type="checkbox"/> Tried, but not Eligible	<input type="checkbox"/> Put on Hold/Complicated Voicemail	<input type="checkbox"/> Fear/Anxiety	<input type="checkbox"/> Wait List/No Appointment Soon Enough
<input type="checkbox"/> Services not at Referred Agency	<input type="checkbox"/> Given Incorrect Information	<input type="checkbox"/> No Phone/Regular Address	<input type="checkbox"/> Staff was Rude/Insensitive
<input type="checkbox"/> Language Barrier	<input type="checkbox"/> Intake Process too Complicated	<input type="checkbox"/> Too Long a Wait	<input type="checkbox"/> Missed Appointment
<input type="checkbox"/> Too Much Trouble/Work	<input type="checkbox"/> Confidentiality Issue	<input type="checkbox"/> Too Ill to Go	<input type="checkbox"/> Felt Well/Did not Need Service
<input type="checkbox"/> Lack of Trust in Provider	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Too Expensive	<input type="checkbox"/> Other (specify) _____
Describe any other referral facilitation activities? (Check all that apply)			
<input type="checkbox"/> Made an appointment for client	<input type="checkbox"/> Discussed service options with client	<input type="checkbox"/> Arranged for social worker to assist	
<input type="checkbox"/> Sat with client while telephoned agency	<input type="checkbox"/> Provided general referral agency information	<input type="checkbox"/> Provided transportation worker	
<input type="checkbox"/> Provided referral slip	<input type="checkbox"/> Provided referral to specific agency/person	<input type="checkbox"/> Help client complete form	
<input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Provided agency location information/map	
<b>Referral Close Date:</b>			

**Bold** indicates the variable is required