COBATEST NETWORK

HIV, SYPHILIS, HCV AND HBV TESTING DATA COLLECTION FORM

Name of the CBVCT site: _____

City of the CBVCT site: _____

Date of visit: ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Testing site: ☐ CBVCT office ☐ Public venue (pharmacy, library) ☐ Outdoors/Van ☐ Amusement venue (café,bar) ☐ Sex work venue ☐ Needle exchange venue ☐ Sauna/sex venue ☐ Other: _____

Who provides the testing: ☐ Health professional ☐ Lay worker (no peer) ☐ Peer ☐ Other: _____

User's Unique identifier (used by the CBVCT service): _____

OR

User's Unique identifier (COBATEST): ☐ Gender (0 cis man, 1 cis woman, 2 trans man, trans woman or non-binary) ☐☐ Day ☐☐ Month of birth ☐☐☐☐ Year ☐ N of older brothers ☐ N of older sisters ☐ Initial letter of mother's name

Client's characteristics:

Gender: ☐ Man (cis) ☐ Woman (cis) ☐ Trans man ☐ Trans woman ☐ Non-binary ☐ Other: _____

Date of birth: ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Foreign national: ☐ Yes → Country of birth: _____ → Year of arrival to this country: *(if migrant)* ☐☐☐☐ Year

☐ No

☐ Don't know

Is the client a: ☐ Tourist ☐ Long-term stay → ☐ Foreign student ☐ Refugee ☐ Resident ☐ Foreign worker ☐ Undocumented migrant ☐ Other: _____ ☐ Asylum seeking migrant ☐ Naturalized citizen

Municipality or home town: _____

Do you have access to free health care services? ☐ Yes ☐ No ☐ Don't know ☐ Other: _____

Have you been homeless during past 12 months? *(living on the street, in a shelter , in a car...)* ☐ Yes, currently ☐ Yes, but not currently ☐ No ☐ Don't know ☐ Refuse to answer

Reasons for testing: (multiresponse)

☐ Risk exposition

- ☐ Unprotected vaginal sex
- ☐ Unprotected anal sex
- ☐ Unprotected oral sex
- ☐ Broken condom
- ☐ Unprotected sex with sex worker
- ☐ My partner has tested positive recently
- ☐ Episode of sharing injection material
- ☐ Other: _____

☐ For control/screening

- ☐ My partner asked me to
- ☐ Before dropping using condom with my partner
- ☐ I wish to have a baby
- ☐ Prenatal screening: before delivery
- ☐ Regular control
- ☐ Only to know my health status
- ☐ I want to start PrEP / Monitoring PrEP
- ☐ Other: _____

☐ Window period in the last test

☐ Clinical symptoms

☐ Other: _____

Reasons for selecting this CBVCT center to be tested: (multiresponse)

☐ I've come here before ☐ A friend told me about this CBVCT ☐ I've seen this CBVCT in a pamphlet ☐ I've found this CBVCT in internet ☐ Other: _____

Behavioural factors:

Sex in the last 12 months with *(multianswer)*: ☐ Men (cis) ☐ Women (cis) ☐ Trans men ☐ Trans women ☐ Non-binary ☐ I haven't had sex ☐ Don't know

Condom use in the last sexual relation with penetration: ☐ Yes ☐ No ☐ Don't know

Received money, drugs, good or services for sex in the last 12 months: ☐ Yes ☐ No ☐ Don't know

STI diagnosed in the last 12 months: ☐ Yes ☐ No ☐ Don't know

Drugs use? ☐ Yes ☐ No ☐ Don't know

Drugs use route? *(multianswer)*:

☐ Injecting →	Last time:	☐ Less than 30 days	☐ Less than 12 months	☐ Ever	☐ Don't know
☐ Sniffing/Snorting →	Last time:	☐ Less than 30 days	☐ Less than 12 months	☐ Ever	☐ Don't know
☐ Smoking →	Last time:	☐ Less than 30 days	☐ Less than 12 months	☐ Ever	☐ Don't know
☐ Oral →	Last time:	☐ Less than 30 days	☐ Less than 12 months	☐ Ever	☐ Don't know
☐ Other →	Which other? _____				

Main drugs used: *(multianswer)* ☐ Cannabis ☐ Cocaine / Crack cocaine ☐ Amphetamine / metamphetamine ☐ MDMA ☐ Heroin / other opioids ☐ New psychoactive substances ☐ Other: _____

Using material of injection that were already used by others in the last 12 months, as: Syringes and/or needles ☐ Yes ☐ No ☐ Don't know; Spoons, filters, water... ☐ Yes ☐ No ☐ Don't know

Using other material for non-injecting drug use that were already used by others in the last 12 months? ☐ Yes ☐ No ☐ Don't know

Have you injected drugs in prison? ☐ Yes ☐ No ☐ Never in prison ☐ Don't know

Are you at opioid agonist treatment currently? ☐ Yes ☐ No ☐ Don't know

STI vaccinations:

Vaccination for Hepatitis A (with all required doses)	☐ Yes	☐ No	☐ Don't know
Vaccination for Hepatitis B (with all required doses)	☐ Yes	☐ No	☐ Don't know
Vaccination for Papilloma virus (with all required doses)	☐ Yes	☐ No	☐ Don't know
Vaccination for Mpox (with all required doses)	☐ Yes	☐ No	☐ Don't know

Testing:

Screening HIV test:

Previous HIV tests ☐ Yes ☐ No ☐ Don't know → Last HIV test performed: ☐ Less than 3 months ☐ Less than 12 months ☐ More than 12 months ☐ Don't know

Previous HIV diagnosis ☐ Yes ☐ No ☐ Don't know → Year of HIV diagnosis : ____ Year

Are you on treatment? ☐ Yes ☐ No ☐ Don't know

HIV test performed ☐ Yes ☐ No → Type of test used: ☐ Rapid blood test ☐ Rapid oral test ☐ Conventional test (Elisa)

Screening test result: ☐ **Reactive** ☐ **Non reactive** ☐ **Undetermined**

Did you perform an extra test? ☐ Yes → Which type of test? ☐ Rapid blood test ☐ Rapid oral test ☐ Conventional test (Elisa); Test result: ☐ Reactive ☐ Non reactive

☐ No

☐ Don't know

Confirmatory test performed ☐ Yes ☐ No ☐ Don't know

Confirmatory HIV test result : ☐ **Positive** ☐ **Negative** ☐ **Inconclusive**

Patient referred to healthcare system ☐ Yes ☐ No ☐ Don't know

Patient linked to healthcare system ☐ Yes ☐ No ☐ Don't know → Date of linkage: ____ Day ____ Month ____ Year

Syphilis test:

Previous syphilis tests ☐ Yes ☐ No ☐ Don't know → Last syphilis test performed: ☐ Less than 3 months ☐ Less than 12 months ☐ More than 12 months ☐ Don't know

Previous syphilis diagnosis ☐ Yes ☐ No ☐ Don't know → Year of last syphilis diagnosis : ____ Year

Syphilis test performed ☐ Yes ☐ No

Type of test used: ☐ Rapid test ☐ Conventional test → Confirmatory test performed? ☐ Yes ☐ No ☐ Don't know

Screening test result: ☐ **Reactive** ☐ **Non reactive**

Syphilis diagnosis: ☐ **Active infection** ☐ **Serological scar (old or cured infection)** ☐ **Unknown** ☐ **Negative**

Patient referred to healthcare system ☐ Yes ☐ No ☐ Don't know

Patient linked to healthcare system ☐ Yes ☐ No ☐ Don't know → Date of linkage: ____ Day ____ Month ____ Year

HCV test

Previous HCV test ☐ Yes ☐ No ☐ Don't know → Last HCV test performed: ☐ Less than 3 months ☐ Less than 12 months ☐ More than 12 months ☐ Don't know

Previous HCV diagnosis ☐ Yes ☐ No ☐ Don't know → Year of last HCV diagnosis: ____ Year

Have you received treatment? ☐ Yes → Which treatment? ☐ Interferon → ☐ Treatment completed ☐ Stopped treatment ☐ Don't know; ☐ New DAA → ☐ Treatment completed ☐ On treatment ☐ Stopped treatment ☐ Don't know; ☐ Don't know

☐ No

☐ Don't know

HCV test performed ☐ Yes ☐ No

Type of test used: ☐ Rapid oral test ☐ Rapid blood test ☐ Conventional test → HCV RNA test performed? ☐ Yes ☐ No ☐ Don't know

Screening test result: ☐ **Reactive** ☐ **Non reactive**

HCV diagnosis: ☐ **Active infection** ☐ **Serological scar (old or cured infection)** ☐ **Unknown** ☐ **Negative**

Patient referred to healthcare system ☐ Yes ☐ No ☐ Don't know

Patient linked to healthcare system ☐ Yes ☐ No ☐ Don't know → Date of linkage: ____ Day ____ Month ____ Year

HBV test

Previous HBV test ☐ Yes ☐ No ☐ Don't know → Last HBV test performed: ☐ Less than 3 months ☐ Less than 12 months ☐ More than 12 months ☐ Don't know

Previous HBV diagnosis ☐ Yes ☐ No ☐ Don't know → Year of HBV diagnosis: ____ Year

HBV test performed ☐ Yes ☐ No

Type of test used: ☐ Rapid blood test ☐ Conventional test → Confirmatory test perfomed? ☐ Yes ☐ No ☐ Don't know

Screening test result: ☐ **Reactive** ☐ **Non reactive**

HBV diagnosis: ☐ **Positive** ☐ **Negative** ☐ **Unknown** → Diagnosed as: ☐ Acute infection ☐ Healthy carrier ☐ Chronic infection ☐ Past cured infection ☐ Don't know

Patient referred to healthcare system ☐ Yes ☐ No ☐ Don't know

Patient linked to healthcare system ☐ Yes ☐ No ☐ Don't know → Date of linkage: ____ Day ____ Month ____ Year

Comments: ----------