COMPREHENSIVE CLIENT NEEDS SCREENING TOOL: RESCREENING

Ryan White Part A: New Orleans EMA
Update: 6/9/10

UIN:_____ **Agency:**_____ **Date:**_____

Person(s) Rescreening client: _____ **Previous Screening Date:**_____

Note: Please indicate any significant changes in the client since the last screening. This tool is only for clients who has been in the Ryan White Part A system 18 months since their initial screening. The Comprehensive Client Initial Needs Screening Tool should be utilized with clients returning to care or enter the Ryan White New Orleans EMA Part A system for the first time. Further questions can be directed to Vatsana Chanthala at vchanthala@cityofno.com or (504) 658-2806.

Section A: LINGUISTIC/CULTURAL PREFERENCES

Last acuity Score:_____ **Current:**_____

Summary/Change noted:_____

_____

Service needed for this section? ☐ Yes (document referral info and follow up) ☐ No ☐ Refused

_____

Section B: FAMILY AND SOCIAL SUPPORT NETWORK

Last acuity Score:_____ **Current:**_____

Summary/Change noted:_____

_____

Service needed for psychosocial support services? ☐ Yes (document referral info and follow up) ☐ No ☐ Refused

_____

Section C: HOUSING/LIVING SITUATION

Last acuity Score:_____ **Current:**_____

(Ensure stable housing to encourage getting into or maintenance in care)

Summary/Change noted:_____

_____

Service needed for this section? ☐ Yes (document referral info and follow up) ☐ No ☐ Refused

_____

Section D: TRANSPORTATION

Last acuity Score:_____ **Current:**_____

(Ensure transportation is not a barrier to getting into or maintenance in care)

Summary/Change noted:_____

_____

Service needed for this section? ☐ Yes (document referral info and follow up) ☐ No ☐ Refused

_____

Section E: HIV KNOWLEDGE/HIV RISK BEHAVIORS

Last acuity Score:_____ Current:_____

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section F: LEGAL NEEDS

Last acuity Score:_____ Current:_____

(Ask client about needs for Estate planning, SSI/SSDI applications, or issues with discrimination due to their HIV status)

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section G: FOOD/NUTRITIONAL ASSESSMENT

Last acuity Score:_____ Current:_____

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section H: FUNCTIONAL ASSESSMENT

Last acuity Score:_____ Current:_____

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section I: MEDICAL HISTORY

Last acuity Score:_____ Current:_____

Are you currently seeing a primary care provider for your HIV condition? ❒ Yes ❒ No

If no, why not? _____

If no, would you like for us refer you to a primary care provider? ❒ Yes ❒ No

If no, why not? _____

In the last 6 months, have you gone to the emergency room for HIV condition? ❒ Yes ❒ No

In the last 6 months, have you been hospitalized for reasons/illnesses related to your HIV condition? (an overnight stay)

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section J: MEDICATION/ ADHERENCE

Last acuity Score:_____ Current:_____

Are you currently/still taking HIV/AIDS medications? ❒ Yes ❒ No ❒ Unknown

If yes, what is the hardest thing about taking your medications?

❒ Forgetting to take meds or missing dosages.

How many dosages have you missed in the past 7 days?

% adherence: _____ / _____ = _____ %

# of dosages missed — total dosage prescribed

❒ Affected by drug side effects
❒ Vision problems
❒ Not taking proper number of meds
❒ Taking meds prescribed for other conditions
❒ Not getting meds due to cost
❒ Coordination of meals/pill taking
❒ Not taking meds on time
❒ Other: _____

If not taking medication, why not? _____

Are you having difficulty getting your medicines? ❒ Yes ❒ No

If yes, please check all reasons that apply:

❒ Don't have transportation
❒ Don't have money
❒ No insurance
❒ Other: _____

Do you have a problem with any of the following? (*Check all that apply*.)

❒ Understanding instructions for taking your medications
❒ Storing medications properly
❒ Keeping medical provider appointments
❒ Adhering to dietary restrictions
❒ Picking up prescription at the pharmacy
❒ Other: _____

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section K: DENTAL CARE

Last acuity Score:_____ Current:_____

In the last year, have you had a dental exam? ❒ Yes ❒ No

If yes, who was it by? ❒ Primary care provider or ❒ Dentist ❒Both

If yes, when and where was your last appointment?_____

If no, do you want us to set you up with a dentist? ❒ Yes ❒ No

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section L: MENTAL HEALTH AND PSYCHOSOCIAL STATUS **Last acuity Score:___ Current:___**

Emotional indicators: **Observations:** ***Do not ask client – rather observe and check box next to each symptom or behavior.***

Physical Appearance	Motor	Attitude	Mood	Speech
❒ Underweight	❒ Tremors/tics	❒ Guarded	❒ Sad	❒ Delayed
❒ Poor complexion	❒ Sluggish	❒ Suspicious	❒ Irritable	❒ Excessive
❒ Disheveled	❒ Hyperactive	❒ Hostile	❒ Elevated	❒ Pressured
❒ Visible skin lesions		❒ Belligerent	❒ Anxious	❒ Incoherent

Do you have (Please check all that apply):

❒ Lack of energy ❒ Angry outbursts ❒ Panic attacks ❒ Sleep disturbance
❒ Sadness ❒ Fears ❒ Anxiety ❒ Poor memory
❒ Poor appetite ❒ Nervousness ❒ Change in appetite or stomach problems
❒ Compulsions *(unable to control oneself)* ❒ Obsessions *(constant thoughts about someone or something)*
❒ Hallucinations *(seeing things, hearing things that aren't there)*

Have you ever sought help for any of those problems? Are you receiving help now?

_____

Depression Indicators

During the past 2 weeks, have you been bothered about feeling down, depressed, or hopeless? ❒ Yes ❒ No

On a scale from 1-10, with 1 as the worst you've ever felt and 10 as the best you've ever felt, where do you think you are today? _____ Two weeks ago? _____

Suicide Indicators

Have you had any thoughts about harming yourself? ❒ Yes, past 2 weeks ❒ Yes, past 12 months ❒ Ever ❒ Never

!!! If you think the person might harm him/herself – do not leave client alone, contact your supervisor !!!

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section M: SUBSTANCE USE/ALCOHOL USE **Last acuity Score:_____ Current:_____**

Remind clients: The next set of questions are related to alcohol and substance use. There are no "right" or "wrong" answers. Your responses won't impact whether or not you receive services from our agency.

Have you smoked ≥100 cigarettes in your entire life? ❒ Yes ❒ No
If yes, how often do you smoke cigarettes? ❒ Every day ❒ Some days ❒ Not at all
If currently still smoking (every day or some days), have you tried to quit in the last 12 months? ❒ Yes ❒ No
(If no, discuss smoking cessation with client)

Are you **currently** using alcohol or illicit drugs? ❒ Yes, please list:_____ ❒ No
If yes, how often do you use? ❒ Once a week ❒Few days week ❒Every day
If currently still use, have you tried to quit in the last 12 months? ❒ Yes ❒ No

Summary/Change noted:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____

Section N: DOMESTIC VIOLENCE

Last acuity Score:_____ Current:_____

I'm going to ask some questions related to your relationship with your partner or spouse.

Please circle the appropriate score for each parameter	**Never**	**Rarely**	**Some-times**	**Fairly often**	**Fre-quently**	
How often does your partner physically hurt you?	1	2	3	4	5	
How often does your partner insult or talk down to you?	1	2	3	4	5	
How often does your partner threaten you with harm?	1	2	3	4	5	
How often does your partner physically scream or curse at you?	1	2	3	4	5	**Final Total**
Total Scores						

A final score of greater than or equal to 11 identifies someone as a victimized respondent and a referral to a domestic violence program is advised. The Louisiana Domestic Violence Hotline at (888) 411-1333 can provide assistance in this process.

Summary/Change noted:_____

_____

Service needed for this section? ☐ Yes (document referral info and follow up) ☐ No ☐ Refused

_____

OVERALL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

Section O: PERINATAL ASSESSMENT (FEMALE ONLY) **Last acuity Score:_____ Current:____**

Have you seen an OB/Gyn in the last 12 months? ❒ Yes ❒ No, how come? _____

Are you pregnant?

❒ Yes, pregnant

If yes, Are you currently seeing someone for your prenatal care? ❒ Yes ❒ No

If yes, where?

Location: _____ Doctor's Name: _____

Date of last visit _____ When is your next appointment? _____

If no, please refer client:

Location:_____ Appointment date:_____ or ❒ client refused

❒ No, delivered already and child is under 2 years

❒ No, not pregnant (skip to summary section at the end of this page.)

Are you planning on becoming pregnant in the future? ❒ Yes ❒ No

If yes, would you like more information about HIV transmission or risk factors? ❒ Yes ❒ No

Are you aware that you can reduce the risk of passing the virus to your child? ❒ Yes ❒ No

For any woman with a child(ren) who is ≤2 years old, please complete the following to ensure the child is receiving appropriate treatment/care.

Child 1:

What is the child's HIV-status? (check only one) *[Answer based on Lab results]*

❒ Unknown/not tested
❒ Indeterminate
❒ HIV-Positive/clinical and CD4 status unknown
❒ HIV-Negative
❒ Asymptomatic (HIV infected with no symptoms)

If answer is *unknown/not tested or indeterminate* does child need to be tested? ❒ Yes ❒ No ❒Not applicable

If no, refer client- Referral Location: _____ Date:_____

Is your child receiving HIV-related medical care? ❒ Yes ❒ No ❒Not applicable

If yes, where/doctor name and contact information? _____

If no, refer client- Referral location:_____ appointment date:_____ or ❒ client refused

Child 2:

What is the child's HIV-status? (check only one) *[Answer based on Lab results]*

❒ Unknown/not tested
❒ Indeterminate
❒ HIV-Positive/clinical and CD4 status unknown
❒ HIV-Negative
❒ Asymptomatic (HIV infected with no symptoms)

If answer is *unknown/not tested or indeterminate* does child need to be tested? ❒ Yes ❒ No ❒Not applicable

If no, refer client- Referral Location: _____ Date:_____

Is your child receiving HIV-related medical care? ❒ Yes ❒ No ❒Not applicable

If yes, where/doctor name and contact information? _____

If no, refer client- Referral location:_____ appointment date:_____ or ❒ client refused

CM Assessment/Comments:_____

_____

Service needed for this section? ❒ Yes (document referral info and follow up) ❒ No ❒ Refused

_____