HELP-US HELP-U, INC. *d/b/a UNIFY Health & Wellness*

FORM 3 CLINICAL ASSESSMENT AND TESTING

Complete at every HIV, HCV, or STI testing visit.

Patient name	Date of birth

Client ID	Date	Staff

Site number	Time	Ordering provider

STOP AND ASK FIRST

☐ Has the patient ever been told they are HIV positive? No, continue ☐ YES — do not rapid test for HIV

If yes, do not rapid test. Provide prevention education, offer a referral back into care, and record it below.

WHERE THE PATIENT IS NOW

☐ HIV: Negative ☐ Positive ☐ Unknown

☐ Hepatitis C: Negative ☐ Positive ☐ Cured ☐ Unknown

☐ Hepatitis B: Negative ☐ Positive ☐ Immune ☐ Unknown

On treatment	Last HIV test	Last HCV test

RISK IN THE LAST 12 MONTHS

☐ Injected drugs ☐ Shared equipment ☐ Sex with men ☐ More than one partner ☐ Sex without a condom
☐ Sex for money or drugs ☐ Sex with an HIV-positive partner ☐ An STI ☐ Jail or prison ☐ No place to stay
☐ No risk identified ☐ Declined to answer

Number of sex partners	Number of needle partners	Substances used

☐ Inject ☐ Smoke ☐ Snort ☐ Swallow

Last used	Overdoses, how many	Last overdose

☐ Currently on MAT ☐ Interested in MAT ☐ Not interested ☐ Prior MAT

A patient who indicates current or prior opioid use and interest in medication treatment should also complete Form 3A before any buprenorphine dose is given.

FORM 3 CLINICAL ASSESSMENT AND TESTING (continued)

TESTING TODAY

Test	Device / lot	Expiry	Sample	Result	Read time
HIV					
Hepatitis C					
Syphilis					
Pregnancy					
Other					

☐ Result given and explained ☐ Prevention education provided ☐ Condoms or supplies offered ☐ PrEP or nPEP discussed
☐ Naloxone given, log completed

IF A RESULT IS REACTIVE

Say it plainly. This is a preliminary result, not a diagnosis. A second test today is needed to confirm it, and staff should stay with the patient through it.

☐ Confirmatory test: Blood drawn now ☐ Booked ☐ Refused

Booked for	**Coordinator told at**
Contact 1	**Contact 2**
Where to find the patient	**Best time**

SCREENED AND REFERRED

☐ Housing ☐ Food ☐ Transport ☐ Benefits ☐ Behavioral health ☐ Risk reduction education

☐ HIV care ☐ HCV treatment ☐ PrEP ☐ MAT ☐ Behavioral health ☐ Primary care ☐ Dental ☐ Optometry
☐ Housing ☐ Confirmatory testing ☐ Other

☐ Referral card given ☐ Entered in linkage log ☐ Entered in testing log

Patient signature	**Date**
Printed name	**Staff signature and title**

Clinician signature and license	CTLS number

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FORM 3A MAT TREATMENT CONSENT

New for this version. Complete once, before the first dose of buprenorphine or other medication for opioid use disorder. This form may be completed verbally with the patient by staff and does not wait for the full Form 3 assessment to be finished.

Patient name	Date of birth

Client ID	Date / time	Staff / provider

BEFORE THE FIRST DOSE

☐ In withdrawal now: Yes ☐ No

Primary substance	Last use (date / time)	Prior MAT (Y/N, type)

☐ Naloxone on hand ☐ Benzodiazepine or alcohol use

READ AND INITIAL

Initial:	
_____	**Treatment consent.** I consent to Medication Assisted Treatment for Opioid Use Disorder using buprenorphine (Suboxone, Subutex, Sublocade, or a generic equivalent). I understand buprenorphine is a controlled substance that can cause physical dependence, and that I must be in withdrawal before my first dose to avoid precipitated withdrawal.

Initial:	
_____	**Overdose risk.** I understand that taking opioids, benzodiazepines, or alcohol together with buprenorphine can cause overdose and death, and that I should tell my provider about every medication and substance I am using.

Initial:	
_____	**Diversion.** I will not share, sell, or divert my medication under any circumstances. I will store it safely, away from children and others. I understand that diversion may result in discharge from the MAT program.

Initial:	
_____	**Treatment plan.** I will attend follow-up appointments and comply with my treatment plan, including random drug testing as requested by my provider.

Initial:	
_____	**If pregnant.** If I am pregnant, I understand buprenorphine is generally safer than continued untreated opioid use, and I will discuss this with my provider.

Initial:	
_____	**Confidentiality.** I understand my substance use disorder records are protected by 42 CFR Part 2, as described in Form 1, and are not disclosed without my separate written consent except in a medical emergency, under a valid court order, or for mandatory reporting of child or elder abuse under Florida Statutes Chapters 39 and 415.

I have read, or had read to me, and understand this consent. I voluntarily agree to MAT treatment on these terms.

Patient signature	**Date / time**
Printed name	**Guardian relationship, if applicable**
Staff / provider signature	**Staff ID / license**