

Section 1

Name (first, last)		Today's Date	
Street Address		City/State	ZIP
Preferred Phone No:		Email:	
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans <input type="checkbox"/> Declined	Race: <input type="checkbox"/> White <input type="checkbox"/> AA <input type="checkbox"/> Nat.Am. <input type="checkbox"/> Asian <input type="checkbox"/> Mixed <input type="checkbox"/> Other_____	
Family size: _____	Income: _____/_____	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Referred by:	Have Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Phys?	
Emergency Contact:		Contact no:	

Section 2

Would you like to receive HIV and Hep C test? <input type="checkbox"/> HIV <input type="checkbox"/> Hep C <input type="checkbox"/> Test already conducted			
Complete PrEP Risk Assessment Form: <input type="checkbox"/> Yes <input type="checkbox"/> No Score: _____			
Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, plan name/policy no/grp no.	

Section 3

Agreement: I, _____ (initials), give consent to participate in the Delaware HIV Consortium's PrEP Navigation program and agree to be contacted by the navigator for follow-up, using the contact information provided. Emergency contact will only be contacted in the event of an emergency.

Disclaimer: I, _____ (initials), understand that the information provided by the PrEP Navigator is for my education and assistance, but that the Navigator is not a medical provider. I should seek information and advice from my medical professional.

Signed: _____ Date: _____

Received by: _____

Date: _____

Signature