

Evaluation Report – Manitoba Youth Centre

*Prepared for Winnipeg Regional Health Authority, Population and Public Health Program
Healthy Sexuality and Harm Reduction Team*

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Background and overview

For approximately four years, Public Health Nurses (PHNs) from the Winnipeg Regional Health Authority's (WRHA) Health Sexuality and Harm Reduction (HSHR) team have been attending Winnipeg Remand Centre (WRC) and Manitoba Youth Centre (MYC) to provide sexually-transmitted and blood-borne infection (STBBI) prevention, screening, and care to those incarcerated there. The overall goal of these services is that "STBBIs in [the] corrections population [are] prevented, detected and treated ... [and that g]eneral health and quality of life are promoted" (Program Logic Model; Appendix A).

STBBIs would be prevented through:

- Access to condoms, lube, sex dams, and safer drug use supplies (where permitted)
- Access to knowledge and information
- Appropriate vaccination

STBBIs would be detected through:

- Appropriate access to testing
- Contact tracing and identification of cases

STBBIs would be treated through:

- Delivering results and administering appropriate treatment and counselling to those infected
- Appropriate linkages to community care

Process of evaluation planning

The evaluation of HSHR's corrections services was structured according to the evaluation tool developed by the 'Towards Evidence-Informed Practice' program of the Ontario Public Health Association (2009), hybridized with tools developed by the Winnipeg-based agency Health in Common.

The process included:

- August 2012: Meeting of HSHR staff: team manager, program specialist, communicable disease coordinator, and corrections PHNs. The purpose of this meeting was to select outside representatives for the 'evaluation team.' The Director of Health Services for Manitoba Justice was asked and agreed to participate. A local epidemiologist with expertise in corrections was asked but unfortunately was not able to participate.
- November 2012: Evaluation team met to brainstorm content to populate the program logic model.
- February 2013: Program logic model was finalised (Appendix A) and draft evaluation questions were identified.
- May 2013: MPH student joined the HSHR team and assumed responsibility for the evaluation. An evaluation framework (with finalised questions and indicators) was drafted and circulated to the evaluation team via email.
- June – July 2013: Evaluation framework finalised (Appendix B). Data collection was undertaken. Analyses were performed and final report written.
- April 2014 – Reports approved by HSHR leadership.

Context: Role of the PHN at MYC

The PHN at MYC attends two or three full days per week. She has an office in the building, though is unable to see clients there. She sees clients in a variety of locales: interview rooms, program rooms, the library, and the cottages. Upon intake at MYC, all youth are offered urine screening for sexually-transmitted infections (STIs) and pregnancy testing by the medical staff at MYC. The PHN delivers urine testing results to residents if they are still incarcerated when the results come in, though *treatment* is usually administered by MYC medical staff, due to high resident turnover (necessitating a quick response). The PHN does contact tracing, as well as pre- and post-test counselling for blood-borne pathogens (BBPs), though medical staff draws the blood for serology.¹ The PHN also administers vaccinations, counsels on family planning and prenatal issues, and delivers general counselling. The PHN also completes numerous referrals to medical care, Project CHOICES, the FASD program, community public health, and others. The PHN ideally wishes to deliver educational sessions to the youth, as well as to the Juvenile Youth Counsellors (JYCs), but does not currently feel that time allows for this.

Process of evaluation

All youth seen have their visits documented on the *Sexually Transmitted & Blood Borne Infection – Corrections* form (Appendix C). Given the particular role of the PHN at MYC (which differs greatly compared with WRC), the form is often filled with writing and documentation in the margins to capture data fields not included on the form. All forms are filed in a binder at MYC, organised by year of visit. If a youth is released from the facility but later returns, their forms are stapled together and filed based on the year of the most recent visit.

¹ Although not routinely offered by MYC medical staff, throat and rectal swabbing is done by the PHN when indicated (currently infrequently).

The writer attended MYC to observe the function of the PHN and to pull data from the forms. The writer did not access corrections charts (i.e. maintained by MYC staff). All forms filed in the 2012 binder were tabulated, as well as forms dating from 2012 but filed (as per above) in the 2013 binder.

The writer created a database in MS Excel. Data from the forms were entered, *sans* identifiers, and then analysed using Epi Info™ 7.

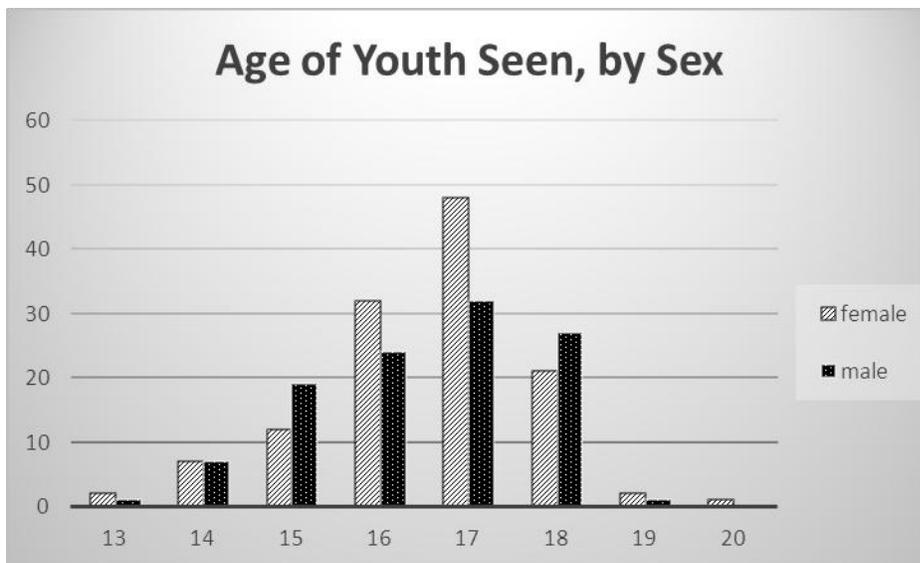
The writer was able to obtain documentation for 199 unique individuals seen by the PHN at MYC between January 1 and December 31, 2012. Many of these youth were seen multiple times, for a total of approximately 700 visits.

Findings

Client Demographics

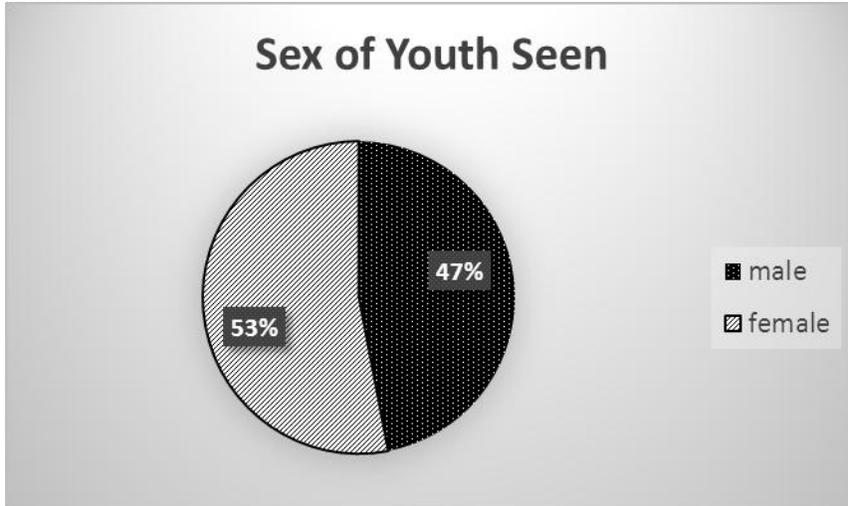
Age

Youth seen had ages ranging from 13 – 20 years old.



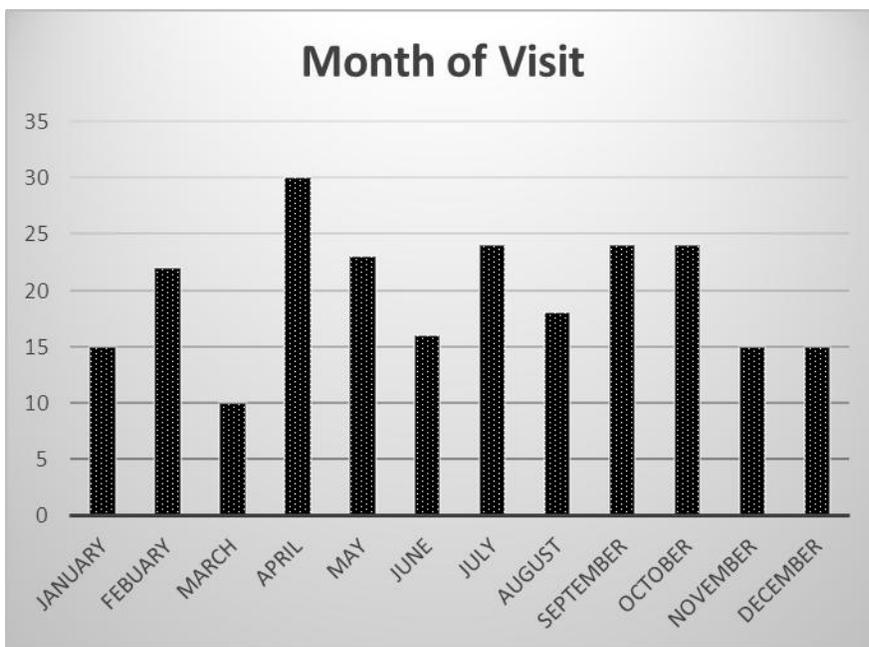
Sex

47% of those seen were male (n=94), 53 % female (n=105).



Month of visit

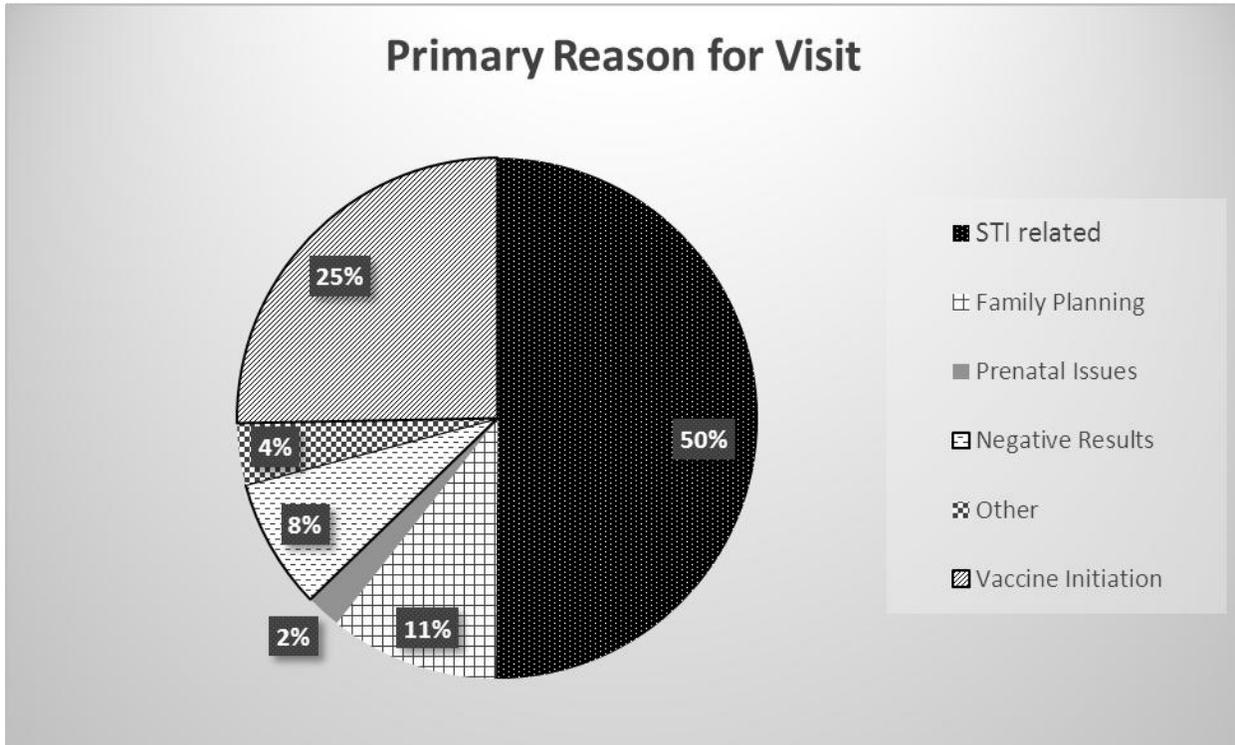
Month of visit varied greatly, from 10 visits in March to 30 in April, though it is important to note that many visits (e.g. administration of vaccine doses only) were not included in this evaluation (see footnote, p. 6).



Reason for Visit

The most frequently reported reason for visit was related to STIs (50%), followed by vaccine initiation (25%), family planning (11%), provision of negative results (8%), other (4%), and prenatal issues (2%).

As above, this does not include visits not included in this evaluation.



Demographics – Miscellany

Six (6) youth self-identified as injection drug users.² All of these youth were female and between the ages of 15 – 17 years old.

No male youth identified as having sex with other men. Twenty-eight (28) female youth identified as having sex with other women.³

Nineteen (19) youth self-identified as having ever traded sex for money, food, a place to stay, etc. 18 of these were female, and 1 male. They were all between the ages of 13 – 18 years old.

² Typical question phrasing: "What drugs have you ever used?", and follow-up prompts.

³ Typical question phrasing: "Do you have sex with men, women, or both?"

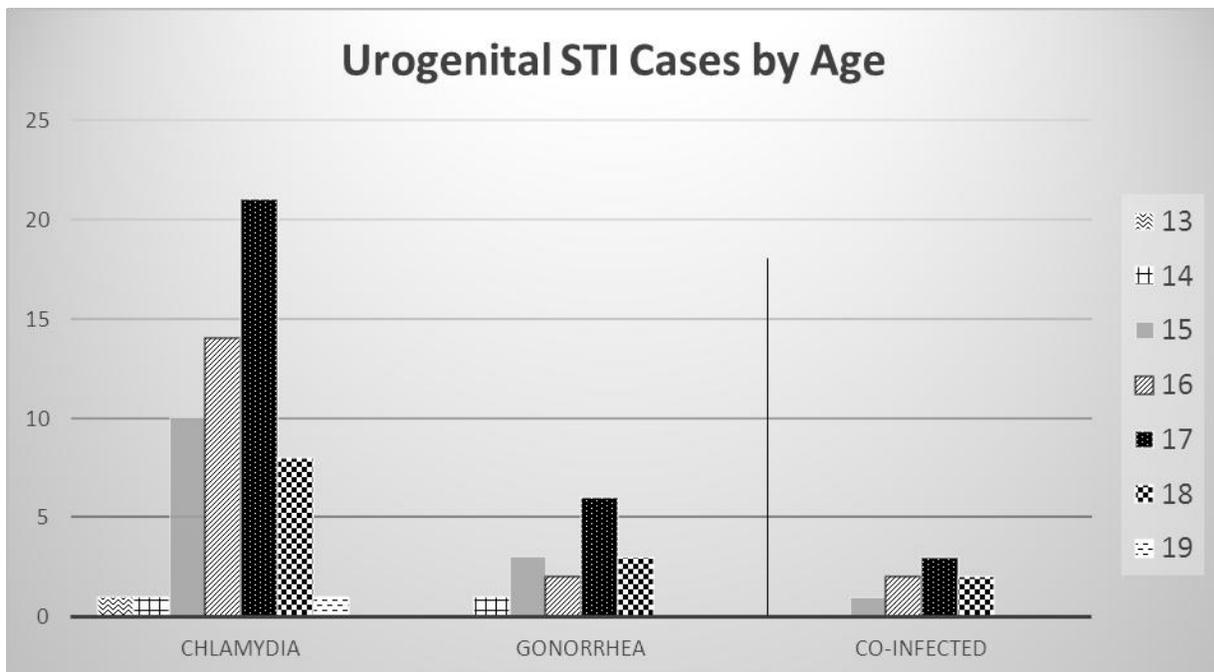
STBBI Incidence⁴

The PHN documented 208 urine STI test results. Sixty-three (63) youth tested positive for at least one STI.

There were 56 cases of urogenital chlamydia identified, translating to a percent positive rate of 26.9%. Twenty-two (22) cases were in females, 34 were in males.

There were 15 cases of urogenital gonorrhea identified, translating to a percent positive rate of 7.2%. Seven (7) cases were in females, 8 were in males. Two individuals had more than one urogenital gonorrhoea infection in 2012.

In 8 instances, the youth was co-infected with both gonorrhea and chlamydia. Four (4) cases were female and 4 male.



BBPs

There were no cases of syphilis, hepatitis C, or HIV detected in 2012.

⁴ Due to time restraints and limited access to off-site records, approximately 70 individuals' charts were not reviewed due to their form containing only minimal information (for example, when the youth was incarcerated for such a brief period that they were not even seen by the PHN, etc.). In certain instances, these excluded forms may have contained (only) *negative* test results, which would not be factored into the denominator used to calculate the percent positive rates. The rates given therefore reflect the best estimate possible based on the information available, but should not be considered research-quality (for the purposes of comparison with studies, etc.).

Evaluation Questions

Evaluation Question 1 – Is the Public Health Nurse’s role in corrections clear, and are the residents aware of services and how to access them?

An evaluation framework to answer this question will be developed and implemented during the next evaluation period. The PHN offered some preliminary impressions:

Indicator 1a – Juvenile Youth Counsellors (JYCs) will be aware of the public health nurse’s role and scope.

The PHN feels that, due to high turnover of staff, there may be some JYCs who are unaware of her role.

Indicator 1b – Residents are aware of how to access the PHN.

The PHN feels that youth are aware of how to access her. Because she delivers results of STI tests, and all youth are offered STI testing on admission, the PHN sees a large number of the residents.

Indicator 1c - Health services in correctional facilities refers residents appropriately.

The PHN feels that referrals are appropriate.

Evaluation Question 2 – Are unvaccinated residents being vaccinated against STBBIs, and are they completing their series?

Indicator 2a – The PHN will assess residents’ immunization status.

Currently, the PHN is unable to access the Manitoba Immunization Monitoring System (MIMS) records or eChart Manitoba consistently within MYC. The PHN can access a youth’s immunization history documented in their corrections chart, but this is only pulled upon the youth’s *first* intake into MYC (for the purpose of accessing their Manitoba Health *Personal Health Identification Number*) and so is potentially out-of-date. When no history exists in the chart, the PHN requests MIMS report from the MYC nursing staff. The PHN notes known vaccination history, documented immunity to hepatitis B, or point in vaccine schedule for all the youth she encounters.

Due to the high number of youth that the PHN endeavours to complete vaccinations for, the process of obtaining MIMS/eChart was identified as arduous by the PHN. Additionally, the process of documentation in multiple places was deemed to occupy a large portion of time.

Despite this, 100% of youth seen had their immunization status assessed (either through past documentation or MIMS) and documented.

Indicator 2b - Immunizations against STBBIs will be initiated when indicated.

Prior to November 2012 most residents would not have been eligible for free vaccination with Gardasil. Regardless, 37 female youth were documented as having initiated Gardasil in 2012, representing 35% of female youth seen. With the expansion of criteria for free vaccination, the number of youth to whom Gardasil is offered will undoubtedly increase for 2013 and beyond.

Eighty-nine percent (89%) of those eligible for and requiring hepatitis B immunization were documented as being offered the series. Recognising that an offer was likely made in all instances where possible, this may reflect a need for a revised form to facilitate documenting reason for no offer (e.g. youth was released before being seen, etc.) and refusals.

Almost all individuals documented as being offered vaccination consented to initiate the series. In rare instances, when requested by the youth, the PHN will also obtain parental consent.

Indicator 2c – Residents who initiate immunization series for hepatitis B and HPV will complete their series.

Although even a single vaccine dose offers some degree of protection, it is still noteworthy that 72% of those who initiated hepatitis B vaccination completed the series within one year (as per guidelines).⁵

- To compare, the rate of completion for Grade 4 students in Winnipeg was 59.2% for the 2011/12 school year (PPH 2012a).

Seventy-nine percent (79%) of those who had Gardasil vaccination initiated completed their series within one year (as per guidelines).

- To compare, the rate of completion for Grade 6 girls in Winnipeg was 60.8% for the 2011/12 school year (PPH 2012b).

Rates of completion are especially impressive in the context of youth being released and later re-incarcerated, with the series generally not interrupted due to the strength of the documentation (tracking and reminder) infrastructure (see indicator 3a).

Although the evaluation was not equipped to capture the amount of community-based (post-release) follow-up done by HSHR PHNs for series completion, it is almost certainly in excess of the 16% of youth who required community follow-up to receive serologic STBBI results (see indicator 4b), due to the fact that most vaccine series require 6 months to complete, as opposed to one-time sharing of results.

⁵ It should be noted that, for hepatitis B vaccination—but not Gardasil—the 2nd and 3rd injections are done by MYC nursing staff (i.e. after the series is initiated by the PHN).

Question 3 - Are those at risk of STBIs being offered testing and receiving their results?

Indicator 3a- Residents requesting PHN services will be seen by the PHN prior to release.

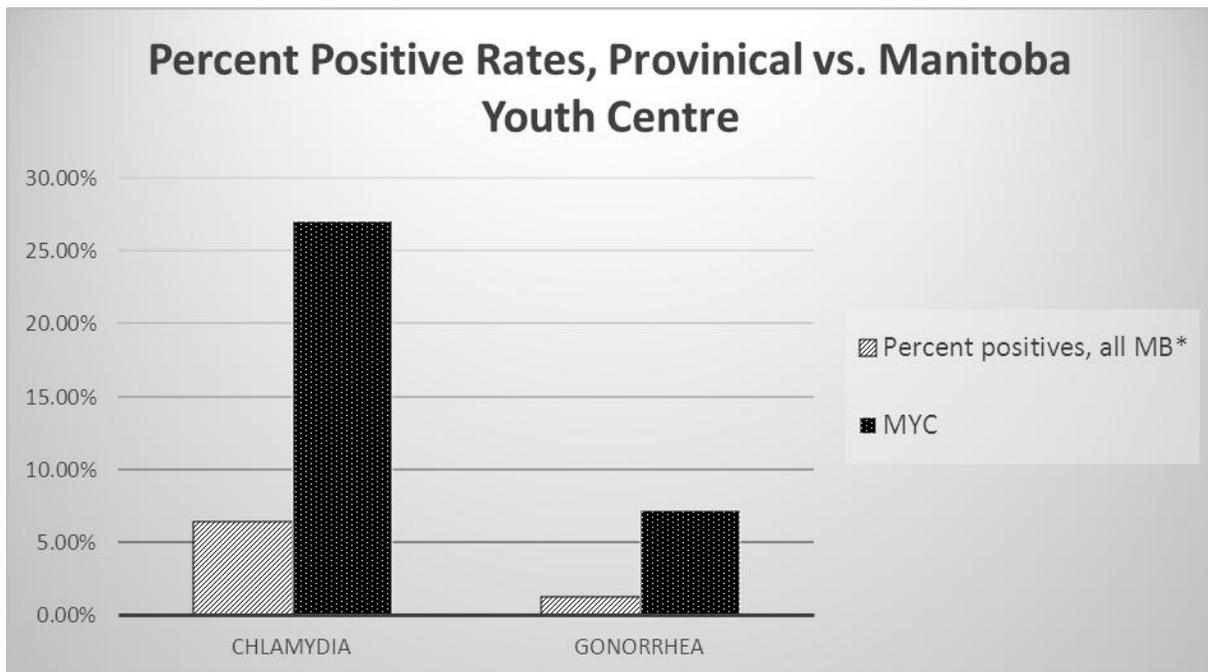
There were 21 residents documented as released prior to being seen by the PHN.

The PHN currently has a system whereby residents who request to be seen (or are due to be seen for vaccination, etc.) have flags placed in their corrections charts, so MYC nursing staff will alert the PHN should the youth return to the facility.

Indicator 3b – Rates/100,000 of positive tests will be similar to, or in excess of Manitoba rates.

This indicator is not necessarily as relevant at MYC (compared to WRC), as the PHN does not perform actual STI testing. STI testing, and often treatment, is done by the correctional nurses.

However, it is worth noting again the striking STI incidence among youth at MYC, reinforcing the extent to which this is a 'priority population' for public health. Of those seen by the PHN with documented urine testing completed by correctional staff, 27% tested positive for chlamydia, and 7.2% tested positive for gonorrhoea.



* (Bullard, 2013)

Indicator 3c – Rates of BBP testing will be at an acceptable percentage to STI testing, based on institutional context.

Of the 210 visits related in some way to STI testing, in 174 (82.3%) instances the youth was documented as being offered BBP screening. 5 youth were documented to have recently completed BBP screening, with no new exposures, and 2 were advised that they were at very low risk for BBPs and were thus advised not to have screening done at that time.

No rationale was documented for the remaining 29, though the likelihood is that the PHN determined—or the youth expressed—that BBP screening had occurred recently enough that a new test was not warranted. A revised documentation form would facilitate the documentation of this fact.

Indicator 3d – All positive cases of STBBIs will be notified of their results.

Due to urine STI testing being offered upon intake at MYC, 99% of positive cases of STIs were documented as having been notified of their results by either the PHN or MYC nurses. One individual was not documented as having been confirmed treated, though documentation suggested that the youth was referred and followed up by public health outside of MYC.

On the other hand, serologic testing (for HIV, hepatitis, and syphilis) is done only after meeting with the PHN and receiving pre-test counselling, with the turn-around time for results closer to 7 days. As such, 16% of youth were released or transferred to another institution prior to receiving these results at MYC. The responsibility of contacting these youth would fall to HSHR community PHNs, despite an absence of dedicated resources for this.

Question 4 – Are individuals being linked appropriately to continuing care in the community?

Indicator 4a – Evidence-based guidelines are in place to guide the PHN’s follow-up in the community.

Although less relevant at MYC (due to the fact that the PHN does not perform actual STBBI testing), it is worth noting that no HSHR guidelines exist specific to corrections nursing. When developed, these should include community follow-up (to deliver results, etc., particularly in the context of negative results at WRC), but indicating where they may or may not be relevant to the MYC role.

Indicator 4b – All positive cases of STBBIs will be notified of their results.

99% of positive cases of STIs were documented as having been notified of their results by either the PHN or MYC nurses. (See indicator 3d).

Indicator 4c – Residents who initiate immunization series for hepatitis B and HPV will complete their series.

Seventy-two percent (72%) of those who initiated hepatitis B vaccination completed the series within one year (as per guidelines).

Seventy-nine percent (79%) of those who had Gardasil vaccination initiated completed their series within one year (as per guidelines).

Question 5 – Are those found to have an STBI treated appropriately and have follow-up interviews and testing completed as per protocols?

5a - All positive cases of STBIs will be notified of their results.

99% of positive cases of STIs were documented as having been notified of their results by either the PHN or MYC nurses. (See indicator 3d)

5b - All positive STI cases will be treated per guidelines.

100% of STI cases were treated per the Canadian Sexually Transmitted Disease Guidelines (PHAC, 2006).

The Canadian Guidelines recommend that all those found to be infected with gonorrhea—unlike with chlamydia positives—undergo screening for HIV and syphilis, as well as immunization against hepatitis B.

Three (3) of 15 individuals who were gonorrhea positive did not have documented offering of serology for HIV or syphilis.

- Upon review of these individuals' HSHR/WRHA health records, one was to be imminently released (i.e. before being able to meet with the PHN), one had already been given a requisition for serologic testing from their primary care provider, and the third had undergone serologic testing only two months prior. A revised *Corrections* form would facilitate the documentation of offer/reason for no offer/refusal of BBP screening (see also indicator 3c).

Two (2) of 15 individuals who were gonorrhea positive did not have documented confirmation of immunity or offering of vaccination.

- A revised *Corrections* form would facilitate the documentation of offer/reason for no offer/refusal of vaccination (see also indicator 2b).

5c - All positive HIV and hepatitis C cases will be linked to medical care.

There were no new identified cases of HIV and hepatitis C in 2012 at MYC. In the event of a confirmed new case, HSHR clinical practice guidelines exist that would dictate appropriate follow-up.

Recommendations

Precise recommendations will be developed through discussion with the evaluation team. The writer recommends that the following represent the most salient findings of the evaluation:

General

- Develop separate evidence-based guidelines for each corrections site (i.e. MYC and WRC) to ensure consistency and sustainability. These would include:
 - if/how to notify released clients of negative results,
 - if/how to follow up with released clients eligible for vaccination and/or in the process of completing a series, and
 - consistent documentation processes, as facilitated by improved forms.
- The need for additional or dedicated resources must be considered in the context of the processes developed as per above.
- Develop a new *Sexually Transmitted & Blood Borne Infection – Corrections* form specific to MYC, in collaboration with the PHN and based on an established model, that better meets program needs.
- Develop strategies, in collaboration with the PHN and Manitoba Justice, to reduce the amount of duplicate charting required.
- Although the youth population at MYC is largely male, young women comprised the majority of clients accessing PHN services. Strategies to engage with male youth should be considered.
- The evaluation team should continue to meet regularly for the purposes of continual quality improvement.

Related to vaccination

- Continue very impressive assessment, offering, and completion of vaccinations.
- The PHN should have prompt, easy access to MIMS/eChart in order to efficiently assess residents' vaccination status.
- Ensure that new/revised form facilitates documentation of assessment of confirmed immunity/previous completion of series for hepatitis vaccination.

Related to STIBBI testing, and treatment

- Continue exemplary offering of BBP screening.
- Ensure that new/revised form facilitates documentation of offering of BBP screening and/or reason for no offer.

Works Cited

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PPH (Population and Public Health program) (2012a). *WRHA Grade 4 Hepatitis B Immunization Program: Public Health-Administered Vaccine by Year of Campaign*. Winnipeg: WRHA. Unpublished.

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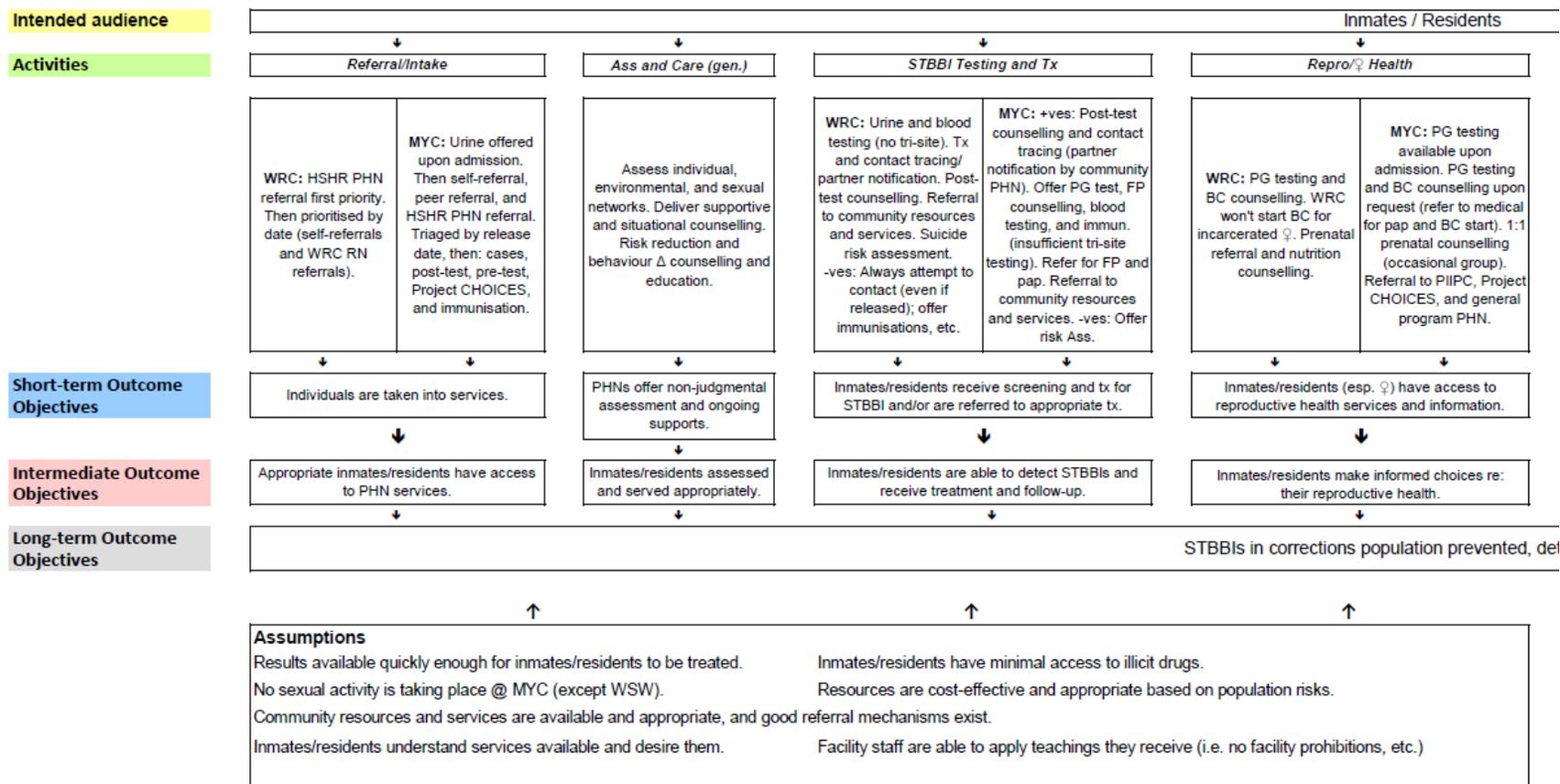
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Appendix A
HSHR Corrections Logic Model – FINAL
March 2013

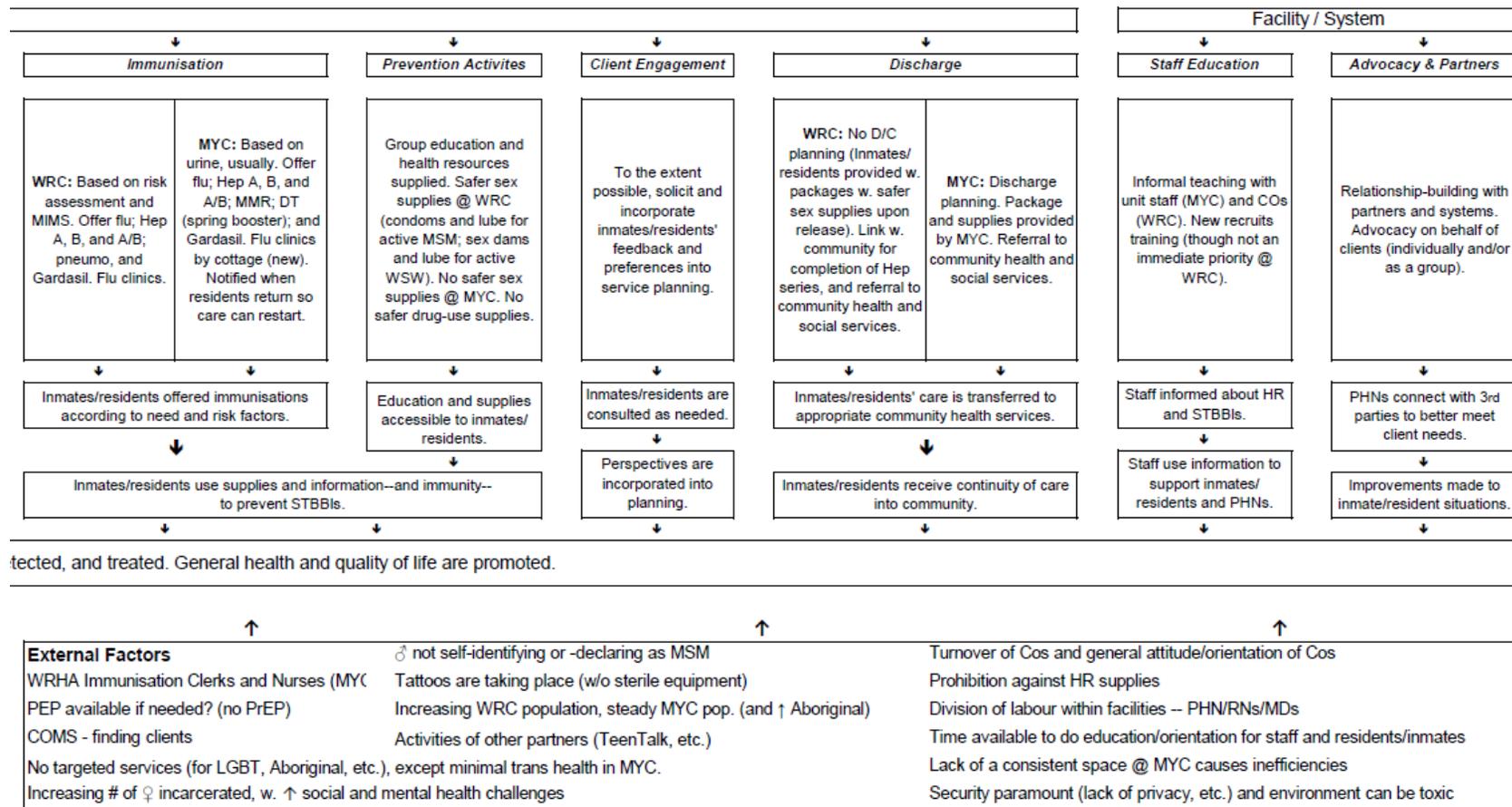
Program: HSHR Corrections Logic Model -- FINAL

Situation:

- High STBBI prevalence in MB correctional facilities in 2009 (20x greater for CT, 10x greater for GC, 4x greater for HIV, and >190x greater for HCV than general population).
- ♀: Rates for CT and GC higher for incarcerated women, especially those aged 13-20. Younger incarcerated women generally have more extensive health and social problems than males. Adult women at high STI and unintended pregnancy risk post-release due to low intention of using condoms or birth control.
- MB incarceration rates are highest in Canada. On the rise (adults): # of individuals in remand, proportion of Aboriginal inmates, and # of female inmates (Youth #s are steady)



Date revised: March 2013



Appendix B

Evaluation Framework – Indicator Review

* Worksheet courtesy of Health In Common

Worksheet 4b. Indicator Review

Question	Indicator(s)	Currently Feasible	Direct	Specific	Useful	Practical	Culturally appropriate	Adequate
1. Are the PHNs' roles in corrections clear, and are inmates ⁶ aware of services and how to access them?	a. Correctional Officers ⁷ will be aware of the PHNs' roles and scope.	N	Y	N	Y	?	Y	Y
	b. Inmates are aware of how to access PHNs.	N	Y	Y	Y	?	Y	Y
	c. Health services in correctional facilities refers inmates appropriately.	N	Y	Y	Y	Y	N	Y
2. Are unvaccinated inmates being vaccinated against STBBIs, and are they completing their series?	a. PHNs will assess inmates' immunization status.	Y/N	Y	Y	Y	Y	Y	Y
	b. Immunizations against STBBIs will be initiated when indicated.	Y	Y	Y	Y	Y	Y	Y
	c. Inmates who initiate immunization series for hepatitis B and HPV will complete their series.	Y/N	Y	Y	Y	Y/N	Y	Y

⁶ Incarcerated youth at MYC are generally referred to as 'residents'; therefore, that language is substituted for 'inmates' throughout the MYC evaluation report.

⁷ Likewise, frontline staff at MYC are generally referred to as Juvenile Youth Counsellors (JYCs); therefore, that language is substituted for 'Correctional Officers' throughout the MYC evaluation report.

3. Are those at risk of STBBIs being offered testing and receiving their results?	a. Inmates requesting PHN services will be seen by PHNs prior to release.	?	Y	Y	Y	Y	Y	?
	b. Rates/100,000 of positive tests will be similar to, or in excess of Manitoba rates.	Y	Y	Y	Y	Y	Y	Y
	c. Rates of BBP testing will be at an acceptable percentage to STI testing, based on institutional context.	Y	Y	Y	Y	Y	Y	Y
	d. All positive cases of STBBIs will be notified of their results.	Y	Y	Y	Y	Y	Y	Y
4. Are individuals being linked appropriately to continuing care in the community?	a. Evidence-based guidelines are in place to guide PHNs' follow-up in the community.	Y	Y	Y	Y	Y	?	Y
	b. All positive cases of STBBIs will be notified of their results.	Y	Y	Y	Y	Y	Y	Y
	c. Inmates who initiate immunization series for hepatitis B and HPV will complete their series.	N/Y	Y	Y	Y	N/Y	Y	Y
5. Are those found to have an STBBI treated appropriately and have follow-up interviews and testing completed as per protocols?	a. All positive cases of STBBIs will be notified of their results.	Y	Y	Y	Y	Y	Y	Y
	b. All positive STI cases will be treated per guidelines.	Y	Y	Y	Y	Y	Y	Y
	c. All positive HIV and hepatitis C cases will be linked to medical care.	Y	Y	Y	Y	Y	Y	Y

Appendix C
Sexually Transmitted & Blood-Borne Infection – Corrections
Form



CLIENT SURNAME

GIVEN NAME

DATE OF BIRTH

MFRN

PHIN

Gender: M h F h ERD/ Court Date: _____

Manitoba Corrections STI/BBP Counselling

Alternate Locating Information _____

Alias _____

Risk Assessment:

Contact for:		Last Test:	
Date of Last Sexual Exposure:		Number sexual contacts in last year:	
Sex with: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both		Number of lifetime partners:	
Condom use: <input type="checkbox"/> always <input type="checkbox"/> most of the time <input type="checkbox"/> some of the time <input type="checkbox"/> never		Age of Sexual Debut:	
Hx of Previous STI		Gang Involved/ Sex With	
Sex Trade Worker/ Sex with		Street Involved	
Hx of Sexual Assault		Recent Immigrant/ Sex With	
Sex Outside Manitoba		Fights	
Tattoo/piercing/acupuncture Scarification/ needle stick		Pregnant Self/ Partner	
Injection Drug Use		Birth Control	
Other Substance Use		Last Pap Test	

Clinical: Symptoms _____

Prevention Education:

- Condoms Oral barriers
 Chlamydia Gonorrhoea Syphilis HIV HPV Herpes HBV HCV Trichomonas _____
 Transmission Incubation Period Complications Signs & symptoms Risk to newborn Testing

Progress Notes:

BBP Pre-test Counselling:

- _____ Discuss transmission modes, signs & symptoms, prognosis, care, & treatment.
- _____ Discuss harm reduction & prevention strategies.
- _____ Discuss that a positive test means there is a presence of antibodies within 3 to 6 months.
- _____ Discuss that a negative test means no antibodies were detected, meaning the person can be in the "window period" or the person is not affected.
- _____ Discuss the confidentiality of the tests, provincial reporting requirements and partner notification.
- _____ Discuss social supports and the stress related to waiting for test results and possible reactions to learning results.
- _____ Discuss by whom and how test results will be communicated to offender.
- _____ Obtain offender's consent for testing. [GC CT VDRL HIV ANTI - HAV HBV HCV Hbsag]

_____ Completed (dd/mm/yy)

_____ Provider Signature and Professional Affiliation

_____ Initials of Provider

Testing/Treatment:**Allergies:** _____

dd/mm/yy	Test	Requisition/Code	Result	Treatment / Follow-up
	Chlamydia			
	Gonorrhoea			
	HbsAG			
	Anti-HBs			
	Anti-HCV			
	Anti-HAV			
	HIV			
	VDRL			
	Pregnancy Test			

Post Test Counselling:

_____ Results of tests explained to offender.

_____ Re-test recommended in _____ months.

_____ Test of cure recommended: _____ yes _____ no When _____

_____ NSTD completed and interviewed for contacts.

_____ Viral Hepatitis Investigation Form completed and interviewed for contacts

_____ Notification of HIV Infection completed and interviewed for contacts

_____ **Discussed legal obligation to notify all sexual partners of HIV + status** (for HIV cases/contacts)_____ Immunization offered. _____ Accepted Refused _____

_____ Referral to _____

_____ Completed (dd/mm/yy)

_____ Provider Signature and Professional Affiliation

_____ Initials of Provider

Progress Notes:_____
_____**Immunization:**

dd/mm/yy	Vaccine	Lot #	Dose	Route/Site	Signature

Antibody :

dd/mm/yy	Test	Result	Plans

Legend

ERD-Expected Date of Release, Ag- antigen, Anti- antibody detection, , VDRL- screen, TP-PA-T palladium particle agglutination, , T-throat,
R - rectal/anal, U-urethra
Organism: HAV – hepatitis A virus, HBV – hepatitis B virus, HCV – hepatitis C virus, HIV – human immunodeficiency virus