

Background Info

Date: ___/___/___

Unique ID: _____
Birth MM | Birth DD | Last 4 Digits SSN

Name: _____ Credentials: _____

Preferred Method of Contact (*check one*):

U.S. Mail E-mail Telephone Fax Other

Appropriate Contact Info: _____

Training Feedback

1. Based on the training experience that you completed three months ago, have you made any changes in the way you work with your individual patients? If so, what kind of changes?

___ Yes ___ No Comments:

2. Based on the same training experience, have you suggested any changes in the way your organization operates? If so, what kind of changes have you suggested? Has the organization made them?

___ Yes ___ No Comments:

3. How often have you used the materials that you received at the clinical training? Which materials were most useful?

___ Never ___ Once or twice ___ 3 to 5 times ___ More than 5 times

Comments:

4. Did you share any information from this training experience with your colleagues when you went back to your organization? If so, what information was most useful to share?

___ Yes ___ No Comments:

5. Have you ever used the HIV Warmline, PEpline, or Perinatal Line (telephone consultation service)?

___ Yes ___ No

If yes, how many times in the past 3 months? _____. If yes, did you find the service helpful? _____

Comments:

6. Now that you have had a few months to reflect on this training and to apply it to your work, do you have any other thoughts or comments about this training experience that you would like to share?

Comments:

7. Please describe what type of topic or education program you would like the AETC to provide to help you further develop your expertise.

8. How would you rate your **current** level of knowledge about the content covered in the clinical training . . .

Expert Very knowledgeable Knowledgeable Not very knowledgeable Novice

9. Please fill in the circle for the one best response to each question (*skip this section if you don't see patients*).

	Every patient, every visit	Every patient, annually	Every new patient at intake	Only if indicated, or if risk factors exist	Only if patient brings it up	Not at all
FOR NON-HIV-INFECTED PATIENTS, HOW OFTEN DO YOU: (<i>if you treat <u>only</u> HIV patients, go on to the next section</i>)						
Ask about risk for HIV infection from sexual or substance use behaviors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discuss HIV/STD prevention strategies?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Routinely offer an HIV test?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FOR HIV-INFECTED PATIENTS, HOW OFTEN DO YOU: (<i>if you don't treat <u>any</u> patients with HIV, skip this section</i>)						
Discuss tobacco, alcohol, and/or other substance use?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discuss treatment adherence?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discuss ways to prevent HIV transmission?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assess for mental health issues?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for completing the post-training survey! Your feedback is very valuable to the AETC and will be used for program improvement. Please return to:

Mountain-Plains AIDS Education and Training Center
University of Colorado at Denver and Health Sciences Center, A-089
Denver, CO 80262

FAX: 303-315-2514 E-mail: Kristen.Overstreet@uchsc.edu

Please do not hesitate to contact the AETC for any further education requests or needs!