GENERAL INSTRUCTIONS
for Completing the HIV Test Form

COMPLETING THE FORM
* Please write legibly.
* Carefully separate the perforated sheet.
* DO NOT use red ink. Please use Blue or Black ink only.
* DO NOT staple, wrinkle or tear form(s).
* DO NOT use white out.
* DO NOT mark on the bar codes of the form ID numbers.
* DO NOT make any stray marks on the form(s), particularly in the fields where answers will appear.
* DO NOT use cursive. Upper case letters preferred.
* DO NOT make copies of this form.
* Please check only one check box unless specified to check all that apply.
* All sections should be completed for each client unless specified in that section. There are sections for All clients, for HIV-negative clients and HIV-positive clients.

ADDITIONAL FORMS
If you need additional forms, please contact the Division of STD and HIV at (304) 558-2195.

RETURNING COMPLETED COPIES
All forms must be returned no later than 30 days after the testing date, regardless of whether the client has returned for results.

WV Department of Health and Human Resources
Bureau for Public Health
Office of Epidemiology and Prevention Services
Division of STD and HIV
350 Capitol Street, Room 125
Charleston, WV 25301
(304) 558-2195

Rev. 6/7/19
West Virginia Bureau for Public Health
HIV Test Form

CLIA ID # ____________________

Session Date: ___ / ___ / ___

Agency Information
Program Announcement: □ PS18-1901 CDC STD □ Other CDC Funded specify: ________ □ Other non-CDC Funded specify: ________
Agency Name or ID: __________________________ Site Name or ID: __________________________ Site Type: (see last page)
Site Address/Zip Code: __________________________ Site County: (3-digit FIPS code) Local Client ID: (optional)

Client Name and Contact Information
First Name: __________________________ Last Name: __________________________ Birthdate: ___ / ___ / ___
Address: __________________________
City/State/Zip: __________________________ Client County: __________________________
Home Phone: (_____) ______-_________ Cell Phone: (_____) ______-_________ Email: __________________________

Client Demographics
Ethnicity: __________________________ Race: (select all that apply) __________________________
Assigned Sex at Birth: __________________________ Current Gender Identity: __________________________

HIV Test Information
HIV Test in last 12 months:
No □ Yes Date: / / ________
□ Don’t Know
Previous HIV Test:
No □ Yes Date: / / ________
□ Don’t Know
Anonymous □ Confidential □ Test Not Done
Reason: __________________________

Final Test Information
HIV Test Election: __________________________ Test Type: (select one) __________________________
□ CLIA-waived point-of-care (POC Rapid Test) □ Laboratory-based Test (Conventional)
□ Preliminary Positive □ HIV-1 Positive
□ Positive □ HIV-1 Positive, possibly acute
□ Negative □ HIV-2 Positive
□ Discordant □ HIV Positive, undifferentiated
□ Invalid □ HIV-1 Negative, HIV-2 Inconclusive
□ Inconclusive, further testing recommended
□ Declined to Answer

Results provided to client:
No □ Yes
□ Yes, client obtained result from another agency

Lab Use Only
INSTI™ Fingerstick whole blood □ Fingerstick whole blood □ Oral fluid
OraQuick Advance® □ Negative □ Preliminary Positive
□ Positive □ Invalid/Indeterminate
Alere Determine™ □ Negative □ Preliminary Positive
□ Positive □ Invalid/Indeterminate
□ Antibody
Additional Testing/Confirmation □ Sent to Lab Corp
□ Sent to OLS
□ Linked to Care Confirmation
With: __________________________ Date: ______________
□ Other: __________________________ Date: ______________
□ Follow-up testing recommended

FINAL RESULT
□ Negative – No lab evidence of HIV Infection
□ Positive – Lab evidence of HIV infection is present
□ Other
□ Follow-up testing recommended
Date: ______________
**West Virginia Bureau for Public Health**  
HIV Test Form

**CLIA ID #: _______________**

**Session Date:** Combo/Combo/Combo

### Agency Information

<table>
<thead>
<tr>
<th>Program Announcement</th>
<th>Other CDC Funded specify</th>
<th>Other non-CDC Funded specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS18-1802</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PS19-1901 CDC STD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Name or ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Type: (see last page)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Address/Zip Code:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site County: (3-digit FIPS code)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Client ID: (optional)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Client Name and Contact Information

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Birthdate: Combo/Combo/Combo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City/State/Zip:</th>
<th>Client County:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone: (<em><strong>) _<strong>-</strong></strong>-</em>___</td>
<td>Cell Phone: (<em><strong>) _<strong>-</strong></strong>-</em>___</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

### Client Demographics

#### Ethnicity:
- Hispanic or Latino
- Not Hispanic or Latino
- Declined to Answer
- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Pacific Islander
- White
- Not Specified
- Don't Know

#### Race: (select all that apply)
- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Pacific Islander
- White
- Not Specified
- Don't Know

#### Assigned Sex at Birth:
- Male
- Female
- Declined to Answer

#### Current Gender Identity:
- Male
- Female
- Transgender Male to Female
- Transgender Female to Male
- Transgender Unspecified
- Another Gender
- Declined to Answer

#### HIV Test in last 12 months:
- No
- Yes Date: __/__/____
- Don't Know

#### Previous HIV Test:
- No
- Yes Date: __/__/____
- Don't Know

### Final Test Information

#### Anonymous Election:
- Confidential
- Test Not Done

#### Reason:
- ________________
- ________________
- ________________

#### Test Type: (select one)
- CLIA-waived point-of-care (POC Rapid Test)
- Preliminary Positive
- Positive
- Negative
- Discordant
- Invalid

(See back page for definitions)

#### Results provided to client?
- No
- Yes

#### Additional Testing/Confirmation:
- HIV-1 Positive
- HIV-1 Positive, possibly acute
- HIV-2 Positive
- HIV Positive, undifferentiated
- HIV-1 Negative, HIV-2 Inconclusive
- HIV-1 Negative
- HIV Negative
- Inconclusive, further testing needed

### Lab Use Only

<table>
<thead>
<tr>
<th>INSTI™ Fingerstick whole blood</th>
<th>OraQuick Advance®</th>
<th>Alere Determine™ Fingerstick whole blood</th>
<th>Additional Testing/Confirmation</th>
<th>FINAL RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td></td>
<td>Antigen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preliminary Positive</td>
<td></td>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invalid/Indeterminate</td>
<td></td>
<td>Invalid/Indeterminate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Client’s Copy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tear Perforation at Top</td>
</tr>
</tbody>
</table>

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### Negative Test Results

<table>
<thead>
<tr>
<th>Is the client at risk for HIV Infection? (optional)</th>
<th>Was the client screened for PrEP Eligibility?</th>
<th>Is the client eligible for PrEP referral?</th>
<th>Was the client given a referral to a PrEP provider?</th>
<th>Was the client provided with services to assist with linkage to a PrEP provider?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No</td>
<td>□ No</td>
<td>Yes, by CDC Criteria</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
<td>Yes, by Local Criteria or Protocol</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>□ Risk Not Known</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>□ Not Assessed</td>
<td></td>
<td></td>
<td>Yes, by CDC Criteria</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Positive Test Results

<table>
<thead>
<tr>
<th>Did the client attend an HIV medical care appointment after this positive test?</th>
<th>Has the client ever had a positive HIV test?</th>
<th>Was the client provided with individualized behavioral risk-reduction counseling?</th>
<th>Was the client’s contact information provided to the health department for Partner Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, confirmed</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
<tr>
<td>□ No, □ Don't Know</td>
<td>No, □ Yes</td>
<td>□ Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Additional Tests (complete for all clients)

<table>
<thead>
<tr>
<th>Was the client tested for the following STDs?</th>
<th>Was the client tested for Hepatitis?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>Hep A</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Hep B</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
<tr>
<td>Chlamydial Infection</td>
<td>Hep C</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
</tbody>
</table>

### PrEP Awareness (complete for all clients)

<table>
<thead>
<tr>
<th>Has the client ever heard of PrEP (Pre-Exposure Prophylaxis)?</th>
<th>Is the client currently taking daily PrEP medication?</th>
<th>Has the client used PrEP anytime in the last 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
</tbody>
</table>

### Priority Populations (complete for all clients)

<table>
<thead>
<tr>
<th>In the past five years, has the client had sex with a male?</th>
<th>In the past five years, has the client had sex with a female?</th>
<th>In the past five years, has the client had sex with a transgender person?</th>
<th>In the past five years, has the client injected drugs or substances?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
</tbody>
</table>

### Essential Support Services (complete as listed below)

<table>
<thead>
<tr>
<th>Health benefits navigation and enrollment (Complete FOR ALL clients)</th>
<th>Evidence-based risk reduction intervention (Complete FOR ALL clients)</th>
<th>Behavioral health services (Complete FOR ALL clients)</th>
<th>Social services (Complete only if POSITIVE test result)</th>
<th>Navigation services for linkage to HIV medical care (Complete only if POSITIVE test result)</th>
<th>Linkage services to HIV medical care (Complete only if POSITIVE test result)</th>
<th>Medication adherence support (Complete only if POSITIVE test result)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
<td>□ Screened for need</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
<tr>
<td>Need determined</td>
<td>Need determined</td>
<td>Need determined</td>
<td>Need determined</td>
<td>Need determined</td>
<td>Need determined</td>
<td>Need determined</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
<tr>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
<td>Provided or Referred</td>
</tr>
<tr>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
<td>□ No, □ Yes</td>
</tr>
</tbody>
</table>

### Local Use Fields (optional)

<table>
<thead>
<tr>
<th>Local Use Field 1</th>
<th>Local Use Field 2</th>
<th>Local Use Field 3</th>
<th>Local Use Field 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Health Department Use ONLY (complete for positive test results)

<table>
<thead>
<tr>
<th>eHARS State Number</th>
<th>eHARS City/County Number</th>
<th>New or Previous diagnosis?</th>
<th>Partner Services Case Number</th>
<th>Was the client interviewed for Partner Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New diagnosis, verified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New diagnosis, not verified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unable to determine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has the client seen a medical provider in the past six months for HIV treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined to answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don't know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See below for definitions)

### Site Types: Clinical
- F01.01 - Inpatient hospital
- F02.12 - TB clinic
- F02.19 - Substance abuse treatment facility
- F02.51 - Community health center
- F03 - Emergency department
- F08 - Primary care clinic (other than CHC)
- F09 - Pharmacy or other retail-based clinic
- F10 - STD clinic
- F11 - Dental clinic
- F12 - Correctional facility clinic
- F13 - Other

### Site Types: Non-clinical
- F04.05 - HIV testing site
- F06.02 - Community setting - School/educational facility
- F06.03 - Community setting - Church/mosque/synagogue/temple
- F06.04 - Community setting - Shelter/transitional housing
- F06.05 - Community setting - Commercial facility
- F06.07 - Community setting - Bar/club/adult entertainment
- F06.08 - Community setting - Public area
- F06.12 - Community setting - Individual residence
- F06.88 - Community setting - Other
- F07 - Correctional facility - Non-healthcare
- F14 - Health department - Field visit
- F15 - Community Setting - Syringe exchange program/HRP
- F88 - Other

### Site Types: Mobile
- F40 - Mobile Unit

### Assurance of Confidentiality Statement:
Form Approved: OMB No. 0920-0696, Exp. 10/31/2021. Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-79, Atlanta, Georgia, 30333, ATTN: PRA 0920-0696. CDC 50.135b(E),10/2007.

### Value Definitions for POC Rapid Test Results

- **Preliminary positive** - One or more of the same point-of-care rapid tests were reactive and none are non-reactive and no supplemental testing was done at your agency.

- **Positive** - Two or more different (orthogonal) point-of-care rapid tests are reactive and none are non-reactive and no laboratory-based supplemental testing was done.

- **Negative** - One or more point-of-care rapid tests are non-reactive and none are non-reactive and no laboratory-based supplemental testing was done.

- **Discordant** - One or more point-of-care rapid tests are reactive and one or more are non-reactive and no laboratory-based supplemental testing was done.

- **Invalid** - A CLIA-waived POC rapid test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport.

### Value Definitions for Diagnosis

- **New diagnosis, verified** - The HIV surveillance system was checked and no prior report was found and there is no indication of a previous diagnosis by either client self report (if the client was asked) or review of other data sources (if other data sources were checked).

- **New diagnosis, not verified** - The HIV surveillance system was not checked and the classification of new diagnosis is based only on no indication of a previous positive HIV test by client self-report or review of other data sources.

- **Previous diagnosis** - Previously reported to the HIV surveillance system or the client reports a previous positive HIV test or evidence of a previous positive test is found on review of other data sources.

- **Unable to determine** - The HIV surveillance system not checked and no other data sources were reviewed and there is no information from the client about previous HIV test results.