Place Barcode Sticker Here

HIV TEST FORM

PART 2

Form Approved: OMB No. 0920-0696, Exp. Date 08/31/2010

CDC requires the following information on **confirmed positives**

Referrals

Was client referred to medical care?

- ⬭ Yes → If yes, did client attend the first appointment?
  - ⬭ Yes
  - ⬭ No
  - ⬭ Don't know
- ⬭ No → If no, why?
  - ⬭ Client already in care
  - ⬭ Client declined care

Was client referred to HIV Prevention services?

- ⬭ Yes
- ⬭ No

Was client referred to PCRS?

- ⬭ Yes
- ⬭ No

If female, is client pregnant?

- ⬭ Yes → If yes, in prenatal care?
  - ⬭ Yes
  - ⬭ No → If no, was client referred for prenatal care?
    - ⬭ Yes → If yes, did client attend first prenatal care appointment?
      - ⬭ Yes
      - ⬭ No
      - ⬭ Don't know
    - ⬭ No
  - ⬭ Don't know
  - ⬭ Declined
  - ⬭ Not asked
- ⬭ No
- ⬭ Don't know
- ⬭ Declined
- ⬭ Not asked

Sample Only

Local Use Fields

L3		L8		L13	
L4		L9		L14	
L5		L10		L15	
L6		L11		L16	
L7		L12		L17	

CDC Use Fields

C3		C6	
C4		C7	
C5		C8	

Notes (Print Only)

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 this 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.