



GENERAL INSTRUCTIONS HIV Test Form

COMPLETING THE FORM

DO write legibly.

DO separate the HIV Program and Client's Copy sheets.

DO check only one check box unless specified to check all that apply.

DO complete all sections for each client unless otherwise specified in that section.

NOTE: Please determine which sections are applicable for ALL CLIENTS, HIV+, and HIV-.

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 make any stray marks on the form(s), particularly in the fields where answers will appear.

DO NOT use cursive. Upper case letters preferred.

ADDITIONAL FORMS

This form is available as a printable / fillable .PDF via email from oeplibsupply@wv.gov and from <https://oeplib.wv.gov>

RETURNING COMPLETED COPIES

All **POSITIVE** results are **REQUIRED** to be mailed to our office within **7 days** after the testing date, regardless of whether the client has returned for results.

All **NEGATIVE** results are **REQUIRED** to be mailed to our office no later than **30 days** after the testing date, regardless of whether the client has returned for results.

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

West Virginia Department of Health Bureau for Public Health

HIV Test Form

CLIA ID # _____

Session Date:

Agency Information

Program Announcement:	PS24-0047		
Agency Name or ID:	Site Name or ID:	Site Type: <i>(see last page)</i>	
Site Address/Zip Code:	Site County: <i>(3-digit FIPS code)</i>	Local Client ID: <i>(optional)</i>	

Client Name and Contact Information (All Clients)

First Name:		Last Name:		Birthdate:	___ / ___ / ___
Address:					
City/State/Zip:				Client County:	
Home Phone:	(____) _____ - _____	Cell Phone:	(____) _____ - _____	Email:	

Client Demographics (All Clients)

Ethnicity:	Race: <i>(select all that apply)</i>	Sex:	Intentionally Left Blank	HIV Test in last 12 months:
Hispanic or Latino Not Hispanic or Latino Don't Know Declined to Answer	American Indian/Alaska Native Asian Black or African American Native Hawaiian/Pacific Islander White Not Specified Declined to Answer Don't Know	Male Female Declined to Answer		No Yes Date: ___ / ___ / ___ Don't Know
				Previous HIV Test:
				No Yes Date: ___ / ___ / ___ Don't Know

Final Test Information (All Clients)

HIV Test Election:	Test Type: <i>(select one)</i>		Results provided to client?
Anonymous Confidential Test Not Done Reason: _____ _____	CLIA-waived point-of-care <i>(POC Rapid Test)</i> Preliminary Positive Positive Negative Discordant Invalid <i>(See back page for definitions)</i>	Laboratory-based Test <i>(Conventional)</i> 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	No Yes Yes, client obtained result from another agency

Lab Use Only (All clients)

INSTI™ Fingerstick whole blood	OraQuick Advance®	Alere Determine™ Fingerstick whole blood	Additional Testing / Confirmation	FINAL RESULT
Negative	Fingerstick whole blood	<u>Antigen</u> Negative	Sent to Other Lab Which Lab: _____	Negative – No lab evidence of HIV Infection
Preliminary Positive	Oral fluid	Preliminary Positive	Sent to Office of Laboratory Services	
Positive	Negative	Positive	Linked to Care Confirmation <i>With:</i> _____ <i>Date:</i> _____	Positive – Lab evidence of HIV infection is present
Invalid/Indeterminate	Preliminary Positive	<u>Antibody</u> Negative	Other: _____	
	Positive	Preliminary Positive		Follow-up testing recommended <i>Date:</i> _____
	Invalid/Indeterminate	Positive		

(HIV Prevention Program Copy)

West Virginia Department of Health Bureau for Public Health

CLIA ID # _____

Session Date: ___ / ___ / _____

Agency Information

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Agency Name or ID:	Site Name or ID:	Site Type: <i>(see last page)</i>		
Site Address/Zip Code:	Site County: <i>(3-digit FIPS code)</i>	Local Client ID: <i>(optional)</i>		

Client Name and Contact Information (All Clients)

First Name:		Last Name:		Birthdate:	___ / ___ / ___
Address:					
City/State/Zip:				Client County:	
Home Phone:	(____) _____ - _____	Cell Phone:	(____) _____ - _____	Email:	

Client Demographics (All Clients)

Ethnicity:	Race: <i>(select all that apply)</i>	Sex:	Intentionally Left Blank	HIV Test in last 12 months:
Hispanic or Latino Not Hispanic or Latino Don't Know Declined to Answer	American Indian/Alaska Native Asian Black or African American Native Hawaiian/Pacific Islander White Not Specified Declined to Answer Don't Know	Male Female Declined to Answer		No Yes Date: ___/___/___ Don't Know
				Previous HIV Test:
				No Yes Date: ___/___/___ Don't Know

Final Test Information (All Clients)

HIV Test Election:	Test Type: <i>(select one)</i>		Results provided to client?
Anonymous Confidential	CLIA-waived point-of-care <i>(POC Rapid Test)</i>	Laboratory-based Test <i>(Conventional)</i>	No
Test Not Done Reason:	Preliminary Positive Positive Negative Discordant Invalid <i>(See back page for definitions)</i>	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	Yes Yes, client obtained result from another agency

Lab Use Only (All Clients)

INSTI™ Fingerstick whole blood	OraQuick Advance®	Alere Determine™ Fingerstick whole blood	Additional Testing/Confirmation	FINAL RESULT
Negative	Fingerstick whole blood	Antigen	Sent to Other Lab Which Lab: _____	Negative – No lab evidence of HIV Infection
Preliminary Positive	Oral fluid	Negative Preliminary Positive	Sent to Office of Laboratory Services	
Positive	Negative	Positive Invalid/Indeterminate	Linked to Care Confirmation With: _____ Date: _____	Positive – Lab evidence of HIV infection is present
Invalid/Indeterminate	Preliminary Positive	Antibody	Other: _____	
	Positive	Negative Preliminary Positive Positive Invalid/Indeterminate		
	Invalid/Indeterminate			Other _____ Follow-up testing recommended Date: _____

(Client Copy)

Negative Test Results

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

Positive Test Results

Did the client attend an HIV medical care appointment after this positive test?	Has the client ever had a positive HIV test?	Was the client provided individualized behavioral risk-reduction counseling?	Was the client 's contact information provided to the health department (DIS) for Partner Services?
Yes, confirmed Yes, client/patient self-report	No Yes	No Yes	No Yes
<i>Date attended</i> No Don't Know	<i>Date of first positive HIV test</i> Don't Know		

What was the client 's most severe housing status in the last 12 months?	If the client is female, is she pregnant?
Literally Homeless Unstably housed or at risk of losing housing Stably housed Not asked Declined to Answer Don't Know	No Yes Don't Know Declined to Answer Is the client in prenatal care? No Yes Don't Know Declined to Answer Was the client screened for need of perinatal HIV service coordination? No Yes Does the client need perinatal HIV service coordination? No Yes Was the client referred for perinatal HIV service coordination? No Yes

Additional Tests (All Clients)

Was the client tested for the following STDs?	Was the client tested for Hepatitis?
Syphilis No Yes <i>test result (optional)</i> Newly Identified Infection Not Infected	Hep A No Yes <i>test result (optional)</i> Positive Negative
Gonorrhea No Yes <i>test result (optional)</i> Positive Negative	Hep B No Yes <i>test result (optional)</i> Positive Negative
Chlamydial Infection No Yes <i>test result (optional)</i> Positive Negative	Hep C No Yes <i>test result (optional)</i> Positive Negative

PrEP Awareness (All Clients)

Has the client ever heard of PrEP (Pre-Exposure Prophylaxis)?	Is the client currently taking daily PrEP medication?	Has the client used PrEP anytime in the last 12 months?
No Yes	No Yes	No Yes

Priority Populations (All Clients)

In the past five years, has the client had sex with a male?	In the past five years, has the client had sex with a female?	In the past five years, has the client injected drugs or substances?	Intentionally Left Blank
No Yes	No Yes	No Yes	

Essential Support Services (Complete for Clients as Applicable)

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

