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 oepshivpsupply@wv.gov and from https://oeps.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

Form ID #

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: *(see last page)*	
Site Address/Zip Code:		Site County: *(3-digit FIPS code)*		Local Client ID: *(optional)*	

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: *(select all that apply)*	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: *(select one)*		Results provided to client?
☐ Anonymous ☐ Confidential ☐ Test Not Done Reason: _____ _____	☐ CLIA-waived point-of-care *(POC Rapid Test* ☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Discordant ☐ Invalid *(See back page for definitions)*	☐ Laboratory-based Test *(Conventional)* ☐ 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 ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	☐ Fingerstick whole blood ☐ Oral fluid ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	Antigen ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate Antibody ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	☐ Sent to Other Lab Which Lab: _____ ☐ Sent to Office of Laboratory Services ☐ Linked to Care Confirmation *With:* _____ *Date:* _____ ☐ Other: _____	☐ **Negative – No lab evidence of HIV Infection** ☐ **Positive – Lab evidence of HIV infection is present** ☐ **Other** _____ ☐ **Follow-up testing recommended** ***Date:*** _____

(Client's Copy)

West Virginia Department of Health
Bureau for Public Health

CLIA ID # _____

Session Date:	___ / ___ / _____

Agency Information

Program Announcement:	☐ PS24-0047				
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 (All Clients)

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

Client Demographics (All Clients)

Ethnicity:	Race: *(select all that apply)*	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: *(select one)*		Results provided to client?
☐ Anonymous ☐ Confidential ☐ Test Not Done ⇩ Reason: _____ _____	☐ CLIA-waived point-of-care *(POC Rapid Test* ☐ Preliminary Positive ☐ Positive ☐ Negative ☐ Discordant ☐ Invalid *(See back page for definitions)*	☐ Laboratory-based Test *(Conventional)* ☐ 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 ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	☐ Fingerstick whole blood ☐ Oral fluid ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	<u>Antigen</u> ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate <u>Antibody</u> ☐ Negative ☐ Preliminary Positive ☐ Positive ☐ Invalid/Indeterminate	☐ Sent to Other Lab Which Lab: _____ ☐ Sent to Office of Laboratory Services ☐ Linked to Care Confirmation *With:* _____ *Date:* _____ ☐ Other: _____	☐ **Negative – No lab evidence of HIV Infection** ☐ **Positive – Lab evidence of HIV infection is present** ☐ **Other** _____ ☐ **Follow-up testing recommended** ***Date:*** _____

(HIV Prevention Program Copy)

Form ID #

Negative Test Results

Is the client at risk for HIV Infection? *(optional)*	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 _______________ *Date attended* ☐ No ☐ Don't Know	☐ No ☐ Yes *Date of first **positive** HIV test* ☐ Don't Know	☐ No ☐ Yes	☐ No ☐ Yes

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 *test result (optional)* ☐ Newly Identified Infection ☐ Not Infected Gonorrhea ☐ No ☐ Yes *test result (optional)* ☐ Positive ☐ Negative Chlamydial Infection ☐ No ☐ Yes *test result (optional)* ☐ Positive ☐ Negative	Hep A ☐ No ☐ Yes *test result (optional)* ☐ Positive ☐ Negative Hep B ☐ No ☐ Yes *test result (optional)* ☐ Positive ☐ Negative Hep C ☐ No ☐ Yes *test result (optional)* ☐ 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 *(Complete **FOR ALL** clients)*	Evidence-based risk reduction intervention *(Complete **FOR ALL** clients)*	Behavioral health services *(Complete **FOR ALL** clients)*	Social services *(Complete **FOR ALL** clients)*	Navigation services for linkage to HIV medical care *(Complete **only** if **POSITIVE** test result)*	Linkage services to HIV medical care *(Complete **only** if **POSITIVE** test result)*	Medication adherence support *(Complete **only** if **POSITIVE** test result)*
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

Form ID #

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

eHARS State Number	eHARS City/County Number	New or Previous diagnosis?	Partner Services Case Number	Was the client interviewed for Partner Services?
		☐ New diagnosis, verified ☐ New diagnosis, not verified ☐ Previous diagnosis ☐ Unable to determine Has the client seen a medical provider in the past six months for HIV treatment? ☐ Yes ☐ No ☐ Declined to answer ☐ Don't know *(See below for definitions)*		☐ Yes, by health department specialist ☐ _____ *Date of interview* ☐ Yes, by a non-health department person trained by the health department to conduct partner services ☐ _____ *Date of interview* ☐ No ☐ Don't know

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: Mobile

- F40 - Mobile Unit

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

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 reactive and no 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.

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