WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR PUBLIC HEALTH

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

Form ID #

West Virginia Bureau for Public Health

HIV Test Form

CLIA ID # _____

Session Date:	__ __ / __ __ / __ __ __ __

Agency Information

Program Announcement:	☐ PS18-1802 ☐ PS19-1901 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 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	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Transgender Unspecified ☐ Another Gender ☐ Declined to Answer	☐ No ☐ Yes *Date:* ____/_____ ☐ Don't Know **Previous HIV Test:** ☐ No ☐ Yes *Date:* ____/_____ ☐ Don't Know

Final Test Information

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

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 Lab Corp ☐ Sent to OLS ☐ 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:*** _____

West Virginia Bureau for Public Health

HIV Test Form

CLIA ID # _____

Session Date:	__ __ / __ __ / __ __ __ __

Agency Information

Program Announcement:	☐ PS18-1802 ☐ PS19-1901 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 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	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Transgender Unspecified ☐ Another Gender ☐ Declined to Answer	☐ No ☐ Yes *Date:* ____/_____ ☐ Don't Know **Previous HIV Test:** ☐ No ☐ Yes *Date:* ____/_____ ☐ Don't Know

Final Test Information

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

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 Lab Corp ☐ Sent to OLS ☐ 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)

Tear Perforation at Top

Rev. 6/7/19

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 with individualized behavioral risk-reduction counseling?	Was the client 's contact information provided to the health department 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 *(complete for 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 *(complete for 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 *(complete for 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 had sex with a transgender person?	In the past five years, has the client injected drugs or substances?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Essential Support Services *(complete as listed below)*

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

Local Use Fields *(optional)*

Local Use Field 1	Local Use Field 2	Local Use Field 3	Local Use Field 4

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 partners 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.

Form ID # | Form ID # | Form ID # | Form ID #