



Printed Barcode

HIV Counseling, Testing and Referral Form



PART 1

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

Agency	Session Date (MMDDYYYY)	Unique Agency ID Number	Intervention ID
	1 2 1 8 2 0 0 7	5 1 1 6	3 6 4 5 3 7 8
	Site ID	Site Type	Site Zip Code
	8 3 5 0 4		

Client	Client ID	Date of Birth (MMDDYYYY)	State	County	Zip Code
	H	0 7	1 9 7 8	VT	
	Ethnicity	Race - Check all that apply	Current Gender	Previous HIV Test?	Self-Reported Result
	<input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Don't know <input type="radio"/> Declined	<input type="checkbox"/> American Ind./AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native HI/Pac. Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Don't know	<input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> Transgender - M2F <input type="radio"/> Transgender - F2M	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Declined <input type="radio"/> Not asked	<input type="radio"/> Positive <input checked="" type="radio"/> Negative <input type="radio"/> Prelim. Pos. <input type="radio"/> Indeterminate <input type="radio"/> Don't know <input type="radio"/> Declined <input type="radio"/> Not asked
					Provide date of last test (MMYYYY) 1 0 2 0 0 4

HIV Test Information	Sample Date (MMDDYYYY)	1 2 1 8 2 0 0 7	1 2 1 8 2 0 0 7	
	Worker ID	8 3 7 3 2	8 3 7 3 2	
	Test Election	<input checked="" type="radio"/> Tested anonymously <input type="radio"/> Tested confidentially <input type="radio"/> Declined testing	<input checked="" type="radio"/> Tested anonymously <input type="radio"/> Tested confidentially <input type="radio"/> Declined testing	<input type="radio"/> Tested anonymously <input type="radio"/> Tested confidentially <input type="radio"/> Declined testing
	Test Technology	<input type="radio"/> Conventional <input checked="" type="radio"/> Rapid HIV TEST 1 <input type="radio"/> Other	<input checked="" type="radio"/> Conventional <input type="radio"/> Rapid HIV TEST 2 <input type="radio"/> Other	<input type="radio"/> Conventional <input type="radio"/> Rapid HIV TEST 3 <input type="radio"/> Other
	Specimen Type	<input type="radio"/> Blood: finger stick <input type="radio"/> Blood: venipuncture <input type="radio"/> Blood spot <input checked="" type="radio"/> Oral mucosal transudate <input type="radio"/> Urine	<input type="radio"/> Blood: finger stick <input type="radio"/> Blood: venipuncture <input type="radio"/> Blood spot <input checked="" type="radio"/> Oral mucosal transudate <input type="radio"/> Urine	<input type="radio"/> Blood: finger stick <input type="radio"/> Blood: venipuncture <input type="radio"/> Blood spot <input type="radio"/> Oral mucosal transudate <input type="radio"/> Urine
	Test Result	<input checked="" type="radio"/> Positive/Reactive <input type="radio"/> NAAT-pos <input type="radio"/> Negative	<input checked="" type="radio"/> Positive/Reactive <input type="radio"/> NAAT-pos <input type="radio"/> Negative	<input type="radio"/> Positive/Reactive <input type="radio"/> NAAT-pos <input type="radio"/> Negative
	Result Provided	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	Date Provided (MMDDYYYY)	1 2 1 8 2 0 0 7	1 2 2 4 2 0 0 7	

Choose one if: Client was not asked about risk factors Client was asked, but no risk was identified Client declined to discuss risk factors

If client risk factor information was discussed, please mark all that apply:

In past 12 months has client had:	...without using a condom?	<input checked="" type="checkbox"/>	Injection Drug Use (IDU)	<input checked="" type="checkbox"/>	Other Risk Factor(s)
Vaginal or Anal Sex	Oral Sex	...with person who is an IDU?	Has client used injection drugs in past 12 months?		
With Male	<input checked="" type="checkbox"/>	...with person who is MSM?	if marked		
With Female	<input type="checkbox"/>	...with person who is HIV positive?	Did client share drug injection equipment?		(see codes on reverse)

Session Activity	Local Use Fields	CDC Use Fields
During this visit, was a risk reduction plan developed for the client? <input checked="" type="radio"/> Yes <input type="radio"/> No	L1 F	C1
Other Session Activities (see codes on reverse)	L2 4	C2



Place Barcode Sticker Here

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PART 2



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CDC requires the following information on confirmed positives

Referrals

Was client referred to medical care?

L

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

No

Don't know

Declined

Not asked

If yes, in prenatal care?

Yes

No

Don't know

Declined

Not asked

If no, was client referred for prenatal care?

Yes

No

If yes, did client attend first prenatal care appointment?

Yes

No

Don't know

Local Use Fields

L3

L4

L5

L6

L7

L8

L9

L10

L11

L12

L13

L14

L15

L16

L17

CDC Use Fields

C3

C4

C5

C6

C7

C8

Notes (Print Only)

Notes section with three horizontal lines for text entry.