



HIV Counseling/Testing Forms Instruction Guide

Directions for Completing the:

DH1628 Laboratory Request Form

DH1628c Post-Test Documentation Form

DH1818 Consent Form

(This Forms Instruction Guide was last revised 12/2010.)

line

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Overview of Changes on the DH1628 Laboratory Request Form

The DH1628 Form was revised in 2010 to:

- **Add the *Birth Sex* variable and make updates to the way the *Risk Factors* are arranged to bring us in line with the National HIV Monitoring and Evaluation (NHM&E) variables from CDC.**
- **Make adjustments to the *Testing History* questions for Incidence Surveillance.** A supplemental Incidence Testing and Treatment History handout is available from your Early Intervention Consultant (EIC). This handout can serve as a cheat sheet for completion of this section, and should be made available to all counselors.

If a client refuses the test, please remember to keep that documentation in their medical record (e.g., written in progress notes). Please do not mail refusals (i.e., “green” site copy) back to the bureau.

DH1628

This form is designed to be read by an Optical Character Recognition (OCR) scanner. The legibility of this form depends on the quality of the handwritten and selected information. Text boxes are used to record handwritten information (e.g., codes, names, dates). When writing letters or numbers in the boxes:

- ✓ **DO NOT** use red ink. Use a pen with blue or black ink.
- ✓ **DO NOT** make any stray marks on the form(s), particularly in the fields where answers will appear.
- ✓ If you mark the wrong oval, put an X thru the oval and mark the correct oval.
- ✓ Use all capital letters and write neatly in your best penmanship. **DO NOT** use cursive.
- ✓ Write only 1 letter or number per box and **DO NOT** have any part of the letter or number touch the edges of the box.

Please follow the below examples of writing information into the DH1628 form:

LETTERS

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

NUMBERS

1 2 3 4 5 6 7 8 9 0

All **applicable** sections must be completed for every client.

DH1628 Laboratory Request Form – Lab (Gold) Copy



SITE ADDRESS **2** SITE NUMBER **3** LOCAL USE **5** LAB COPY PLEASE SEE BACK INSTRUCTIONS **7**
 COUNSELOR ID **4** PRE-TEST COUNSEL DATE **6**
8 BLOOD ORAL DBS CD4/R V. LOAD GENOTYPE GENOTYPE PLUS RAPID TEST REACTIVE

Last Name **9** First Name M.I. Address **10**
 City **11** State Zip Code County **12**
 Phone 1 **13** Phone 2 **13** Medicaid # **14** SSN

Date of Birth **15** Ethnicity (Select one) **17** Race (Select one or more) **18** Self-Reported Gender **19** Birth Sex **20** Pregnant **21** In Prenatal Care **22**
 Country of Birth **16**

Testing History Questions
 Previous HIV Test? **23**
 Result of Last HIV Test **24**
 Ever had a POSITIVE HIV test? **25** IF YES, date of First Positive HIV test?

Risk Factors **30** Post 12 months EVER
 Vaginal or Anal Sex
 with a male
 with a female
 with transgender
 If yes to any of the above:
 with a person of unknown HIV status
 with an HIV-positive person
 with a person who exchanges sex for drugs/money/other
 with an IDU
 with an MSM (FEMALE only)
 with an anonymous partner
 with a Hemophiliac or transfusion/transplant recipient
 without a condom
 while intoxicated and/or high on drugs or alcohol
 for drugs, money or other items
 Oral Sex
 Injection drug use
 If IDU, shared injection equipment
 Victim of sexual assault
 STD diagnosis
 Perinatal exposure to HIV
 Jail/Prison/Detention Center
 No risk identified
 Client refused to discuss risk(s)
 In the past 12 months, how many different:
 Sex partners? Needle-sharing partners?

Ever had a NEGATIVE HIV test? **27** IF YES, date of Last Negative HIV test?

Number of negative HIV tests within 12 months before last positive test (Refused, Don't Know) **28**

Have you ever taken any Antiretroviral or HIV medicine? **29** If YES, when was it? First day of ARV or HIV medication Last day of ARV or HIV medication

RAPID TEST SITE USE ONLY OraQuick Uni-Gold Clearview Other Result Given? YES NO
 Test Kit Lot Number Test Kit Expiration Date Reactive Non-Reactive
 Time Test Began Time Test Read **32** REFUSED CONFIRMATORY TEST

2nd RAPID TEST **33** 2nd test MUST be a different brand AND sites must have Bureau of HIV/AIDS approval
 Test Kit Lot Number Test Kit Expiration Date Result Given? YES NO
 Time Test Began Time Test Read REFUSED CONFIRMATORY TEST

Instructions for Completing the DH1628 Laboratory Request Form

***This is a 2-part form. Please note that when filling out this form, most of the information will be written on the top **GOLD** (Lab) copy.

Site-Specific Information

- 1 **Permanent Barcode** The barcode will be preprinted on each copy of the DH1628. The stickers that are located on the bottom of the green copy will match this barcode. ***It is not necessary to place these stickers over the bar code on the DH1628 *unless* the bar code is not able to be scanned (accidentally gets torn, etc.).
- 2 **Site Address** This is the physical address of the registered test site. It is imperative that this field be completed to ensure that if the site number is incorrect, missing or transposed, the results can still be mailed to the correct location in a timely manner.

***If you are using a pre-printed sticker or stamp, be sure that no other data fields are obstructed.
- 3 **Site Number** Write the assigned counseling/testing site number here. **Be sure that you use the correct site number.** Many agencies and CHDs have multiple site numbers. It is important to use the right one so that the test results are returned in a timely manner and your data will accurately show where you are conducting testing.



NOTE: Sites are encouraged to use client demographic stickers instead of hand writing the site address and site number. Please contact your EIC for more information on how to obtain the stickers.

The site prefixes are as follows:

01 - Anonymous	08 - Correctional Facility
02 - STD	09 - College/University
03 - Drug Treatment	10 - Private M.D.
04 - Family Planning	11 - Special Study/TOPWA
05 - Prenatal/OB	12 - Community-Based Organization
06 - TB	13 - CHD Field Visit
07 - CHD Adult Health	



NOTE: The site address and site number are the only pieces of information that link your specimen to your site. Failure to include this information **WILL** prevent you from receiving a test result.

Site-Specific Information (continued) ⁶

- 4 **Counselor ID** This is a local use field that will help each site track who is doing the testing. This field can be letters (for example counselor initials) or numbers and would be determined at the local level.
- 5 **Local Use** This field does *not* have to be completed for every client. However, it can be used to track tests that were performed for specific reasons, such as smallpox related, court-ordered testing or AIDS Drug Assistance Program (ADAP). Test sites can use this field to track other data of interest, such as test location, intervention, referred from, funding source, etc.
- 6 **Pre-Test Counsel Date** Completely and legibly fill in the month, day and year (e.g., 01/02/11) the client was pre-test counseled. The pre-test counsel date *must* match the date the specimen is taken and the date the consent form (DH1818) is signed. **This field MUST be completed** for each test, including rapid HIV tests.
- 7 **Lab Copy / Please See Back for Instructions** This is a reminder to send the lab (gold) copy of the DH1628 form to the laboratory with the specimen and that selected instructions and codes can be found on the back of the green copy of the form.
- 8 **Blood, Oral, Dried Blood Spot (DBS), CD4/8, Viral Load, Genotype, Genotype Plus** Clearly mark the correct specimen type and/or test requested. When confirming a rapid test this box should be used to indicate the type of confirmatory specimen being sent to the lab, not the specimen used for the rapid test.

Only mark the “RAPID TEST REACTIVE” box when sending a specimen to the lab to confirm a reactive rapid test. **Do not mark this box for any other reason.** Marking this box does not mean you will get your results back more quickly – it only alerts the lab that the current specimen has been sent to confirm a reactive rapid test.



NOTE: If the form is being used by a qualified medical provider to order a CD4/8, viral load and/or genotyping test, the counselor needs to fill out the site information and the demographic section of this form only. All other sections of this form may be left blank.

Demographic Information

- 9** **Please complete** the client's legal last name, first name and, if applicable, middle initial. Please remember to print in capital letters with one letter per box. It is ok to use pre-printed client information labels as long as they include all the requested information and they do not cover up other fields. Please be sure the label prints correctly and all fields are complete.



NOTE: When using a pre-printed label, make sure and place the label on both the yellow and green copies of the DH1628.

- 10** **Please complete** client's street address. If the client does not have a permanent address, please obtain an address where the client is most likely to be located.

- 11** **Please complete** the city, state and zip code of residence.

- 12** **Please write** the county and include any **additional locating information** (aliases, frequent hangouts, etc.) that might assist a Disease Intervention Specialist (DIS) in locating this client if necessary (i.e., a client that may not have returned for results).

- 13** **Please write** the client's primary and secondary phone number.

- 14** **Please write** the client's Medicaid (if applicable) and Social Security Number (SSN).



NOTE: If a client does not have their **social security** card, can't remember or refuses to give the number, please do not keep them from being tested. Leave the field blank. **DO NOT WRITE** any other identification number (e.g., green card, driver's license, pseudo social security number, etc.) or other information in this field.



****Medicaid Number** This field should be completed for **all clients** that consent to **CONFIDENTIAL** testing and have a Medicaid number. The laboratory uses this number to bill Medicaid directly, so it is imperative that the number be **complete and legible**.



NOTE: For anonymous tests, only collect the client's city, state, county, and zip code of residence.

Demographic Information (continued)

- 15** **Date of Birth** Please write the client's month, day and year of birth. Year of birth must include all four digits, e.g., 1963.
- 16** **Country of Birth** Write in the client's country of birth. If the client was born in the United States, please write USA. If the name of the country is longer than the number of boxes provided, please write in as many letters as possible, while making the name of the country clear.
- 17** **Ethnicity** Please mark **only one** box: either "**Hispanic or Latino**", "**Not Hispanic or Latino**" or "**Don't Know**" for each client. This field represents how the client **self-identifies**. If the client refuses to identify with any of the choices given, please mark "**Refused**".
- 18** **Race** Clients may identify with more than one race. Please mark **all** appropriate boxes. If the client refuses to self-identify with any of the choices given, please mark "**Refused**".

Race Definition: A client's self-reported classification of the biological heritage with which he/she most closely identifies. This section uses standard OMB race codes.

- ✓ **American Indian/Alaska Native:** A person having origins in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.
- ✓ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ✓ **Black/African American:** A person having origins in any of the black racial groups of Africa.
- ✓ **Native Hawaiian/Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ✓ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.



***Please note that if the client seems confused by the choices, the counselor should explain the choices to increase the likelihood of obtaining correct information. If the client is still unable to identify a race, mark "**Don't Know**".

Demographic Information (continued)

- 19** **Self-Reported Gender** Please mark only **one** box: either “**Male**”, “**Female**”, “**Transgender/M to F**”, “**Transgender/F to M**” or “**Transgender/Unspecified**” for each client. This field represents how the client **self-identifies**.
- 20** **Birth Sex** The biological sex assigned to the client at birth, (i.e., the sex noted on the client's birth certificate). *Instructions:* Indicate whether the client reports being physically born a male or female (i.e., being born with male or female genitalia), or “**Refused**” to answer.
- 21** **Pregnant** This field must be filled out for every **biological female** that is being tested. Please mark “**Yes**” if she is sure she is pregnant, “**No**” if she is sure she is not pregnant and “**Don't Know**” if she is not really sure. If the client refuses to answer this question, please mark “**Refused**”.



NOTE: Please note that this field is particularly important because STD investigators will prioritize HIV-infected pregnant women.

- 22** **In Prenatal Care** If the client is pregnant, please mark “**Yes**” if she is in prenatal care, “**No**” if she is not in prenatal care, and “**Don't Know**” if she doesn't know. If the client refuses to answer this question, please mark “**Refused**”.



NOTE: The form is highlighted to remind counselors to complete the pregnancy field for all females, and the prenatal care field for those who are pregnant.

Testing History Questions

23 **Previous HIV Test** Please ask the client if they have ever been tested for HIV before today (this test).

Please mark only one box for this question.

- ✓**Yes** The client has been tested for HIV before today.
- ✓**No** The client has not been tested for HIV before today.
- ✓**Don't Know** The client does not remember or does not know if they have ever been tested for HIV. This box is not to be used for clients who don't remember their last test result.
- ✓**Refused** The client refused to answer this question.

24 **Result of last HIV Test** If the client has had several previous tests, please use the most recent test to answer this question.

- ✓**Positive** They have been tested for HIV before today **and** they received their test result **and** their last test result was positive. If positive, please complete the **Previous Positive** section.
- ✓**Negative** They have been tested for HIV before today **and** they received their test result **and** their last test result was negative.
- ✓**Reactive Rapid Test** They have been tested for HIV before today with a rapid test **and** they received a reactive result that was not confirmed.
- ✓**Indeterminate** They have been tested for HIV before today **and** they received their test result **and** their last test result was indeterminate.
- ✓**Don't Know** They have been tested for HIV before today **and** they did not receive their test result.
- ✓**Refused** The client refused to answer this question.



NOTE: Regardless of the answers to these questions, you must ask and record a response for “**Ever had a positive HIV test**” and “**Ever had a negative HIV test.**” Instructions for completing these questions begin on page 11.

Testing History Questions (continued)

Complete these sections in their entirety for all clients. When asking clients about dates of previous tests, please encourage them to think back to the most exact date. If they cannot recall exact dates, ensure you collect the exact four digit year.

25 Ever had a POSITIVE HIV test?

Ask the client if they ever had a positive HIV test.

Date of FIRST positive test

Ask the client when was the first time they tested positive for HIV. **This is not their most recent test result but rather the very first HIV-positive test result they ever had.** Ask for the two digit **month**, the two digit **day**, and the four digit **year**.

If the client does not know the exact date leave blank, for example if the client reports month and year, record 05/___/2009. Do not record '99' for unknown information.

26 State of First Positive?

Write the abbreviation for the state (e.g., FL, GA, AL, etc.) where the first positive test was performed and confirmed. Leave blank if the test was performed in another country.

27 Ever had a NEGATIVE HIV test?

Ask the client if they ever had a negative HIV test.

Date of your LAST negative test

Ask the client for the date of their last negative HIV test. Ask for the two digit **month**, the two digit **day**, and the four digit **year**.

If client does not know the exact date leave blank, for example if the client reports month and year, record 05/___/2009. Do not record '99' for unknown information.

28 Number of negative HIV tests within 24 months before first positive test?

Ask the client how many negative tests they had within 24 months of first testing positive. If client does not know, record '99' for unknown or '77' if they refuse to answer question.



If the client has never tested positive, record the number of negative HIV tests they have had within the last 24 months.

Antiretroviral History

29 Have you ever taken any Antiretroviral or HIV medicine?

This question must be asked of each client regardless of whether this is their first HIV test or they have tested previously.

Clients without an HIV-positive diagnosis may have taken, or may currently be taking, antiretroviral medications. This includes persons that are being treated for hepatitis B and are taking antiretrovirals (e.g., epivir/lamivudine). This also includes persons who are taking antiretrovirals (e.g., AZT) to prevent HIV infection after exposure. This is called post-exposure prophylaxis (PEP).



NOTE: Because antiretroviral medications can increase the chances of a false result on the test that is used to estimate incidence, it is essential that this information be collected.

✓If the client has ever taken antiretroviral medications or is currently taking them, mark “Yes”.

“If YES, which ones?” Medication names and the codes to be used to identify them for this question are listed on the back of the form. If the medication is not listed on the back of the form, the provider should make sure it is an antiretroviral drug and write “00 New Drug Not Listed”.

NOTE: Prompts that might assist the client include a medication chart, and/or the provider might ask about the color, size, or shape of the medication, or whether it was a liquid or had to be refrigerated.

✓If the client has never taken antiretroviral medications or is not currently taking them, mark “No”.

✓If the client is not sure (they do not know or they do not remember) if he or she has ever taken antiretroviral medications or is currently taking them, mark “Don’t Know”.

✓If the client refuses to answer the question, mark “Refused”.

“First Day of ARV or HIV Medication” The date of the first day on which the client took antiretroviral medication. Ask for the two digit **month**, the two digit **day**, and the four digit **year**. If the client does not know the exact date leave blank, for example if the client reports month and year, record 05/___ / 2009. Do not record ‘99’ for unknown information.

“Last Day of ARV or HIV Medication” The date of the last day on which the client took antiretroviral medication. Ask for the two digit **month**, the two digit **day**, and the four digit **year**. If the client does not know the exact date leave blank, for example if client reports month and year, record 05/___ / 2009. Do not record ‘99’ for unknown information. **If the client is currently taking ARV or HIV medication, then the last day of ARV or HIV medication should be the date that the interview is being completed.**

Risk Factors

- 30 Client risk data provides information on the risk behaviors of the client that may increase a client's risk of HIV exposure or transmission. These data also provide information on the social and/or environmental circumstances that may influence a client's engagement in high-risk behaviors (such as whether they have been incarcerated). These data are useful in planning prevention services that target those risks.

When asking questions about past behavior or events, it is important to define the time period. The "recall period" is the period of time for clients to consider. The recall periods are "Past 12 months" and "Ever". Please be aware that risk factors must be captured for the "Past 12 months" as well as "EVER" (over any time period). Select all of the activities that the client has been involved in within the last 12 months that would place him or her at risk of either being exposed to HIV or transmitting HIV. The sexual risk factors in this section ("Sex with male", "Sex with female" and "Sex with transgender") apply only to vaginal and anal sex, and should include both unprotected and protected sex. If the client reports "Sex with male", "Sex with female" and/or "Sex with transgender" then complete the section "If yes to any of the above".

Sex (vaginal or anal) with a male: The client has had vaginal or anal intercourse (protected or unprotected) with a male.

Sex (vaginal or anal) with a female: The client has had vaginal or anal intercourse (protected or unprotected) with a female.

Sex (vaginal or anal) with transgender: The client has had vaginal or anal intercourse (protected or unprotected) with a person known to him or her to be a transgender.

Risk Factors (continued)

30

continued



NOTE: Respond to the following only if the client reported a vaginal or anal sex with male, female, or transgender. For each of those client risk factors identified, indicate additional risk characteristics that describe the client's risk for either being exposed to HIV or transmitting HIV. If the client did not report having vaginal or anal sex with a male, female, or transgender, then do not select any additional client risk factors. If the client knows he or she has an additional client risk factor (e.g., sex "with a person who is an IDU") but he or she does not remember the sex of the person (in this case the IDU), the provider should ask the client for his or her best guess as to whether the partner(s) were male, female, or transgender.

- **with a person of unknown HIV status:** The client has had sex with a person whose HIV status is unknown to either the client or to the partner.
- **with an HIV-positive person:** The client has had sex with a person who he or she knows was HIV+.
- **with a person who has sex for drugs/money/other items:** The client has had sex with a person who he or she knows exchanges sex for drugs/money.
- **with an IDU:** The client has had sex with a person who he or she knows to be an IDU.
- **with an MSM:** The client is female and has had sex with a person who she knows has male-to-male sex.
- **with an anonymous partner:** The client has had sex with a person whose identity was unknown to the client. A person's identity is a set of behavioral or personal characteristics by which that person is known. This can include information about a person's name, address, and habits that allow the client to identify the person.
- **with a Hemophiliac or transfusion/transplant recipient:** The client has had sex with a person who he or she knows has hemophilia or is a transfusion/transplant recipient.
- **without a condom:** The client has had sex without using a condom.
- **while intoxicated and/or high on drugs or alcohol:** The client used alcohol and/or illicit drugs before and/or during sex.
- **for drugs/money/other items:** The client participated in sex events in exchange for drugs or money or something they needed.

Risk Factors (continued)

30

continued

Oral Sex: The client has had (protected or unprotected) oral sex.

Injection drug use: The client has used illicit injection drugs/substances (including narcotics, hormones, silicon, etc.).

➤ If the client is an IDU, ask if they have shared injection equipment (includes needles, syringes, cookers, cotton, etc.).

Victim of sexual assault: The client has been a victim of penetration or other sexual activity in which body fluids may have been exchanged.

STD diagnosis: The client has been diagnosed with an STD other than HIV.

Perinatal exposure to HIV: The client was born to an HIV-infected mother.

Jail/Prison/Detention Center: The client has been incarcerated.

No risk identified: No risk identified is selected when the client was asked about Risk Factors, but reports none of the risk factors listed.

Client refused to discuss risk(s): The client declines or is unwilling to discuss risk factors.

In the past 12 months, how many *different*:

➤ **Sex partners** did the client have? Please complete the statement using an actual **number** (not “several” or “a few”).

➤ **Needle-sharing partners** did the client have? **Example:** This includes any type of needle-sharing for drugs, tattoos, etc. Please complete the statement using an actual **number** (not “several” or “a few”).



NOTE: It is crucial to accurately identify a client’s risk behaviors. Accurate identification of risks can be used to determine if a program designed to target specific risk behaviors is effectively identifying appropriate clients. This knowledge also allows providers the ability to make referrals appropriate to a client’s risk behavior. Thus, if a client does not report any HIV risk behaviors, it is important for a provider to understand the reason a client wants to get tested.



In this version of the form, **Hemophiliac/Blood recipient** and **Occupational exposure** have been deleted. If a client identifies no other risk but one of these, you may note this in the local use field.

Rapid Test Use Only

31 Complete this section ONLY when a rapid test will be performed.

Test Type

Please indicate which rapid test is being used.

Test Kit Lot Number

Record the lot number printed on the test kit pouch. Do not use the lot number printed on the outside of the box of test kits.

Test Kit Expiration Date

Record the test kit expiration date printed on the test kit pouch. Do not use the test kit expiration date printed on the outside of the box of test kits.

Type of Sample Tested

- ✓ If the specimen is collected from the client's fingertip using a lancet, mark "Finger Stick".
- ✓ If the specimen is collected from the client's vein, mark "Venous Blood Draw". This includes specimens obtained by dipping the collection loop into the test tube containing venous blood.
- ✓ If the specimen is collected from the client's mouth, mark "Oral Fluid".

Time Test Began

Record the time test processing began (i.e., when the device was inserted into the developer solution vial or after the buffer solution was added. For example: If processing began at 2:47 pm, write **02:47** in the boxes. If processing began at 11:15 am, write **11:15** in the boxes.

Time Test Read

Record the time the test result was read. If the test device was read at 3:07 pm, write **03:07** in the boxes. If the test device was read at 11:35 am, write **11:35** in the boxes. Please note the time read must be in accordance with the manufacturer's instructions.



NOTE: Times are based on a 12-hour clock; however, it is not necessary to note a.m. or p.m.

Rapid Test Use Only (continued)

31

continued

Was Client Given Rapid Test Result?

- ✓ If the client was given the result of their rapid test, mark “**Yes**”.
- ✓ If the client was not given the result of their rapid test, mark “**No**”.



NOTE: Providers should make every effort to ensure that the client receives the rapid test result. To ensure that the client does not leave during the processing period, counselors can offer risk reduction counseling, videos, interventions or other educational activities.

What was the Result?

- ✓ If the client has a reactive rapid test, mark “**Reactive**”.
- ✓ If the client has a negative rapid test, mark “**Non-Reactive**”.



NOTE: If the client has a reactive rapid test, indicate what type of confirmatory sample you are sending to the laboratory by marking either “**Blood**” or “**Oral**” at the top of the form. Also place a mark next to “**Rapid Test Reactive**” in the **upper right corner** of the form.

Marking the **Rapid Test Reactive** box alerts the lab that a confirmatory specimen is being sent in and must be processed in accordance with rapid testing guidelines. Send the top (gold) copy of the DH1628 form to the state laboratory with the specimen. Add a scan id sticker from the bottom of the DH1628 for all reactive specimens sent to the lab for confirmation to the **REACTIVE RAPID TEST ID FORM** for that month, and include the form in your monthly mailing to the Bureau.

32

REFUSED CONFIRMATORY TEST If the client refuses further testing to confirm the reactive rapid test, mark “**REFUSED CONFIRMATORY TEST**”, and send that form with the other negative rapid tests as described below.



NOTE: The top (GOLD) copy **MUST** be double enveloped, with the inner envelope clearly marked “**CONFIDENTIAL**” and sent to the bureau via traceable mail, DHL, UPS, Federal Express (or other similar carrier) within one month of testing to:

Bureau of HIV/AIDS
2585 Merchants Row Blvd.
Tallahassee, FL 32399
Attention: Rapid Testing Data/Room 335

Rapid Test Use Only (continued)

- 33 **2nd RAPID TEST** This section should only be completed by test sites approved and trained by the Bureau of HIV/AIDS to conduct a dual rapid test algorithm. The 2nd rapid test should only be performed when the 1st rapid test is reactive. The 2nd rapid test must be a different brand (made by a different manufacturer, e.g., Clearview Complete followed by OraQuick Advance).

Instructions for Completing the Return Appointment Card and Using the Test Site (Green) Copy of the DH1628 Laboratory Request Form

34 Return Appointment Date

The return appointment date is located at the center of the bottom of the gold copy of the form. Write the month, day and year of the agreed-upon date the client will return for their test result.

35 Return Appointment Card

Complete this card when scheduling a return appointment for the client. This card is perforated so it can be easily separated from the rest of the form and given to the client. **It is critical that the client be given this card as it serves as identification for receipt of test results, and is the ONLY link to an anonymous test result.**

Place one of the scan id stickers located next to the card in the space provided on the card. Write the return appointment date and location in the spaces provided. Write a phone number where you can be reached in case the client needs to contact you about the appointment.



NOTE: To protect the client's privacy, we recommend using only a street address and not the agency's name in the return appointment location field.

Labels on the bottom of this form should match the bar-coding on the top of the gold and green forms. One bar-coded sticker should be placed on the specimen when sending it to the laboratory.

The completed test site (green) copy is to be kept in the client's medical record. Instructions and codes for completing the DH1628 can be found on the back of the green copy

Please do not mail the green copy to the
Bureau of HIV/AIDS.

DH1628c Post-Test Documentation Form

<p>Scan ID #</p> <p>Last Name, First Name, MI Street address County City State Zip COB DOB race/sex ethnicity PREGNANT: Risks:</p> <p>date collected: worker #: date received: local use: date reported:</p>	<p>①</p> <p>②</p>	<p>POST-TEST DATE</p> <table style="margin: auto;"> <tr> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td style="text-align: center; font-size: small;">Year</td> </tr> </table> <p>_____</p> <p>COUNSELOR ID</p>				Month	Day	Year	<p>Lab ID #</p> <p>Negative test, retest in: ③</p> <p style="text-align: right; font-size: small;">_____/_____ Month Year</p>		
Month	Day	Year									
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Laboratory Interpretation:</td> <td style="width: 20%;">EIA:</td> <td style="width: 20%;">WB:</td> <td style="width: 30%;"></td> </tr> <tr> <td>CD4 Count:</td> <td>CD8 Count:</td> <td>CD4/8 Ratio:</td> <td>Viral Load:</td> </tr> </table> <div style="border: 1px solid blue; border-radius: 10px; padding: 10px; margin-top: 10px; width: fit-content;"> <p>Mail-To Facility Name SITE NUMBER Street address City State Zip Attention:</p> </div> <div style="border: 1px solid red; border-top: none; padding: 10px; margin-top: 10px;"> <p><u>Comments</u></p> </div>				Laboratory Interpretation:	EIA:	WB:		CD4 Count:	CD8 Count:	CD4/8 Ratio:	Viral Load:
Laboratory Interpretation:	EIA:	WB:									
CD4 Count:	CD8 Count:	CD4/8 Ratio:	Viral Load:								
<p>TEST SITE COPY</p>		<p>CONFIDENTIAL</p>									
<p><u>Original Testing Site</u> Submitting Facility Name SITE NUMBER Attention:</p>											

Instructions for Completing the DH1628c HIV Post-Test Documentation Form

It is required that all clients be offered post-test counseling. The *Test Site* copy of the DH1628c must be retained by the test site and the client should be given the *Client* copy of the DH1628c. The *Test Site* copy of the DH1628c must be available for Quality Assurance audits by the Department.

Test sites are no longer required to mail the bureau copy/yellow copy of the DH1628c. This rule change applies to both HIV-negative and HIV-positive clients. This data is now collected electronically by the Department from other data resources.

- 1 Post-Test Date** On the *Test Site* page of the DH1628c, indicate date of post-test counseling session by entering the date in the corresponding boxes for the two-digit month, two-digit day and two-digit year of post-test session (e.g., 11/28/09).
- 2 Counselor ID** You may also include the counselor initials or number in the spaces provided. Your Counselor ID is assigned to you by the agency you are employed by or are volunteering with.
- 3 Retest date** If the client tested negative and might be in the window period, indicate the month and year the client was told to return for another HIV test.



NOTE: ALL HIV-INFECTED CLIENTS SHOULD BE LINKED TO CASE MANAGEMENT, MEDICAL CARE, AND THE LOCAL STD PROGRAM FOR PARTNER SERVICES. A copy of the HIV Laboratory Result Form should accompany the referral forms to the local STD program manager within ONE (1) working day of the post-test counseling session.



NOTE: Within ONE (1) working day of the missed appointment, the following information should be submitted to the local STD Program Manager for all HIV-INFECTED CLIENTS WHO DID NOT RETURN FOR POST-TEST COUNSELING:

- a) A copy of the HIV Laboratory Result Form
- b) Client locating information.



State of Florida Department of Health
CONSENT FORM
ANONYMOUS HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

HIV testing is a process that uses FDA-approved tests to detect the presence of HIV, the virus that causes AIDS and to see how HIV is affecting your body. The most common type of HIV test detects antibodies produced by the body after HIV infection. Test results are highly reliable but a negative test does not guarantee that you are healthy. Generally, it can take up to three months for HIV antibodies to develop. This is called the "window" period. During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive HIV test means that you are infected with HIV and can also give it to others even when you feel healthy.

If you consent by filling out and signing this form, a specimen will be taken and you will be tested. Generally, test results will be available in about 2 weeks. If a rapid HIV test is used, results will be available the same day. If the rapid test detects HIV antibodies, it is very likely that you are infected with the virus, but this result will need to be confirmed. You will be asked to submit a second specimen for further testing. The results from this confirmatory test will be available to you in about 2 weeks.

If you test positive, you will be asked about sex and/or needle-sharing partners and voluntary partner counseling and referral services (PCRS) will be offered to you.

Finding HIV infection early can be important to your treatment, which along with proper precautions, helps prevent spread of the disease. If you are pregnant, there is treatment available to help prevent your baby from getting HIV. If you have any questions, please ask your counselor, physician, or call the Florida AIDS Hotline (1-800-FLA-AIDS or 1-800-352-2437) before signing this form.

CONSENT GIVEN	1	Client must indicate if they wish to be tested by checking "Yes" or "No"
<input type="checkbox"/> YES <input type="checkbox"/> NO Check Here	2	I have been informed about HIV testing and its benefits and limitations. I understand that some tests require a second specimen to be taken from me for further testing. I consent to be tested.
Date		
	3	Place DH1628 Scan ID sticker here
4	5	
Witness Signature		Date

Instructions:

1. Please ensure that clients read and understand the information provided on this consent form. If clients are unable to read or understand this information, the counselor should read it to them.
2. After anonymous clients receive information about the HIV antibody test, they must indicate their consent by checking "yes" or "no", dating the form, and, for those who choose testing, placing the scan ID# on the form.
3. All consent forms must have a witness signature. The counselor conducting the pre-test counseling can serve as the witness.

DH1818, 05/05. (Obsoletes 03/04, 07/97 editions which may not be used) Stock Number: 5740-000-1818-9

Instructions for Completing the DH1818 Consent Form (Anonymous)

- ① The client should indicate if they wish to take the HIV test by checking either “Yes” or “No”.
- ② The client should write the date (month, day and year) on the line provided.
- ③ The client should place the Scan ID sticker in the box provided to indicate s/he has been informed about and consents to HIV testing.
- ④ The counselor should sign their name, as a witness, on the line provided.
- ⑤ The counselor should write the date (month, day and year) on the line provided.



**State of Florida Department of Health
 CONFIDENTIAL HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST
 CONSENT FORM**

HIV testing is a process that uses FDA-approved tests to detect the presence of HIV, the virus that causes AIDS and to see how HIV is affecting your body. The most common type of HIV test detects antibodies produced by the body after HIV infection. Test results are highly reliable but a negative test does not guarantee that you are healthy. Generally, it can take up to three months for HIV antibodies to develop. This is called the "window period". During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive antibody HIV test means that you are infected with HIV and can also give it to others even when you feel healthy.

Other tests can detect the presence of virus in your blood, measure the amount of virus in your blood, measure the number of T-cells in your blood, or see if the virus is susceptible to HIV/AIDS medications. Some of these tests may require a second specimen to be obtained for further testing. Generally, test results will be available in about 2 weeks. If you consent by filling out and signing this form a specimen will be taken and you will be tested.

If a rapid HIV test is used, results will be available the same day. If the rapid test detects HIV antibodies, it is very likely that you are infected with the virus, but this result will need to be confirmed. You will be asked to submit a second specimen for further testing. The results from this confirmatory test will be available to you in about 2 weeks.

If you test positive, the local health department will contact you to help with counseling, treatment, case management and other services if you need them and want them. You will be asked about sex and/or needle-sharing partners, and voluntary partner counseling and referral services (PCRS) will be offered to you. The HIV test result will become part of your confidential medical record. If you are pregnant, or become pregnant, the test results will become part of your baby's medical record.

Finding HIV infection early can be important to your treatment, which along with proper precautions, helps prevent spread of the disease. If you are pregnant, there is treatment available to help prevent your baby from getting HIV. If you have any questions, please ask your counselor, physician, or call the Florida AIDS Hotline (1-800-FLA-AIDS or 1-800-352-2437) before signing this form.

CONSENT GIVEN REQUIRED	<i>Client must initial the consent statement and then sign below. The consent form must be dated and witnessed.</i>
1	
<input type="checkbox"/> YES <input type="checkbox"/> NO Initial Here	I have been informed about HIV testing and its benefits and limitations. I understand that some tests require a second specimen to be taken from me for further testing.
2	3
Date	Signature of Client or Legal Representative
4	Client's Printed Name
5	6
Witness Signature	Legal Representative's Relationship to the Client (If Applicable)

OPTIONAL	
7	
<input type="checkbox"/> YES <input type="checkbox"/> NO Initial Here If Applicable	If I move out of the area or live somewhere else, I want my results forwarded to the appropriate public health care provider or the physician listed below so that I may be informed of my results and receive post-test counseling.
	8
	Preferred Physician or Facility and their Mailing Address

- Instructions:
1. Please ensure that clients read and understand the information provided on this consent form. If clients are unable to read or understand this information, the counselor should read it to them.
 2. The client must initial each of two consent statements as appropriate and sign and date the bottom of the form.
 3. If a legal representative of the client signs the consent form, their relationship to the client must be indicated on the appropriate line.
 4. In accordance with state protocol, if the client wants their results forwarded, the STD Program Manager will handle this transaction.
 5. All consent forms must have a witness signature. The counselor conducting the pre-test counseling can serve as the witness.

Instructions for Completing the DH1818 Consent Form (Confidential)

- ① The client should place their initials on the “Yes” line to indicate they have been informed about and consent to HIV testing. The client should place their initials on the “No” line to indicate they have been informed about and decline HIV testing.
- ② The client should write the date (month, day and year) on the line provided.
- ③ The client or client’s legal representative should sign their name on the line provided.
- ④ The client should **print** their name on the line provided.
- ⑤ The counselor should sign their name, as a witness, on the line provided.
- ⑥ If a legal representative of the client signs the DH1818 Consent Form, their relationship to the client must be indicated on the line provided.
- ⑦ The client should place their initials on either the “Yes” or the “No” line to indicate if s/he would like to have their HIV test results forwarded to another health care provider.
- ⑧ If “Yes” is chosen, please complete the information requested (the name and address of their preferred physician).