

Office of AIDS
PRE Section

HIV6 CIF, LRF & CIS Training

Welcome to:

The HIV6 Counseling Information Form,
HIV Antibody Test Laboratory
Requisition Form Training



Agenda

*9:30 a.m.-12:00 p.m. - HIV6 Counseling Information Form
& HIV Antibody Lab slip*

1:00 p.m.-4:00 p.m. - HIV6 Computer System

Introduction

- Sixth version of the form
- Content developed over the years by HIV counselors, coordinators, OA, and reviewing HIV test forms from other states
- Includes relevant information for HIV prevention and serves as a guide for the counseling session
- Developed to be easy to follow for data entry personnel

HIV6 CIF (front side)

State of California—Health and Human Services Agency
Department of Health Services
Unique Office of AIDS Client Number

HIV COUNSELING INFORMATION FORM

Administrative Information
Agency/ LHD no.: [] [] [] [] [] [] [] []
Site no.: [] [] [] [] [] [] [] []
Clinic type: (mark one) (1) Alternative test site (8) Street outreach
 (2) Family planning (9) Mobile van
 (3) STD clinic (10) TB clinic
 (4) Aic./drug treatment (11) Youth drop in
 (5) Detention facility (12) Other health department
 (6) Primary care/CHC (13) Other, specify _____
 (7) HIV test
Client's test election: (mark one) (1) Tested anonymously
 (2) Tested confidentially
 (3) Declined testing/not tested

Counseling Dates
(date and initials) Service Date (mm/dd/yy) Initials (xyz)
Risk assessment: [] [] [] [] [] [] [] []
Follow-up contact: [] [] [] [] [] [] [] []
(to reset missed disclosure/post disclosure sessions by confidential clients)
Disclosure session: [] [] [] [] [] [] [] []
(this may be the same date as risk assessment for rapid test results)
(carefully verify anonymous clients using Client Information)
 (1) Mark if post disclosure counseling scheduled.
Post disclosure session: [] [] [] [] [] [] [] []
(for rapid test positive confirmatory disclosures and post disclosure)
(carefully verify anonymous clients using Client Information)

Client Information
Race/ethnicity: (mark one or two) (1) African American (not Hispanic)
 (2) American Indian/Alaskan Native
 (3) Asian/Pacific Islander
 (4) Hispanic/Latino(a)
 (5) White (not Hispanic)
 (6) Other, specify _____
Date of birth: (mm/dd/yy) [] [] [] [] [] [] [] []
Gender and pregnancy: (mark one) (1) Male
 (2) Female
 (3) Pregnant female
 (4) Transgendered: male to female
 (5) Transgendered: female to male
 (6) Other, specify _____
Sexual orientation: (mark one) (1) Heterosexual (straight)
 (2) Bisexual
 (3) Gay, lesbian, queer, or homosexual
 (4) Other, specify _____
 (5) Client doesn't know
Residence county: [] [] [] [] [] [] [] []
Residence zip code: [] [] [] [] [] [] [] [] [] [] [] []
 (1) Mark if client is homeless.
Client was referred by: (mark one) (1) HIV+ partner
 (2) PCRS/partner notification
 (3) OA NIGHT outreach (incentive/referral)
 (4) Other outreach worker
 (5) HIV education program
 (6) AIDS telephone hotline
 (7) Other AIDS agency
 (8) Alcohol/drug treatment program
 (9) M.D./health clinic
 (10) Friend/relative
 (11) Media (TV, radio, print)
 (12) Internet
 (13) No identifiable referral source
Client's reason for testing: (mark one) (1) Reconfirming HIV+ result
 (2) Reports AIDS-like symptoms
 (3) Has current HIV+ partner
 (4) Had past HIV+ partner
 (5) TB diagnosis
 (6) STD related
 (7) Hepatitis diagnosis
 (8) Pregnancy
 (9) Risky behavior
 (10) Starting a new relationship
 (11) Partner request
 (12) Rape/assault
 (13) Exposure to blood
 (14) Immigration
 (15) Other, specify _____

HIV Testing History
Number of prior HIV tests: (circle one)
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9+)
Date of last test result: (mm/yy) [] [] [] [] [] []
Last test result: (mark one) (1) Positive
 (2) Negative
 (3) Inconclusive
 (4) Did not return for results
Risk Reduction Steps
Risk assessment stage of change: (mark one) (1) Not thinking about it (Precontemplation)
 (2) Thinking about it (Contemplation)
 (3) Ready for action (Preparation)
 (4) Action
 (5) Maintenance
Immediate risk reduction step:
(to be accomplished by client before disclosure)
At disclosure: risk reduction step(s): (mark one) (1) No step established at risk assessment
 (2) Client made no effort
 (3) Step attempted
 (4) Step achieved
Post disclosure/short-term risk reduction step(s):
Long-term risk reduction step(s):

Referrals
Client referrals:
Record at risk assessment (RA), disclosure (D) and post disclosure (PD). Order by marking 1 for your primary referral. Other referrals should be numbered 2 and 3.
(1) NONE
(2) Referral list only
(3) Other HIV testing
Risk/harm reduction
(4) Prevention case management (PCM)
(5) HIV education & prevention services
(6) Follow-up HIV counseling
(7) Prevention skill development
(8) Prevention support group
(9) Individual psychotherapy/counseling
Substance use services
(10) Alcohol/drug treatment
(11) Twelve step program
(12) Needle exchange program
HIV positive referrals
(13) Early intervention program (EIP)
(14) HIV case management
(15) HIV medical care/evaluation/treatment
(16) PCRS/partner notification
Other referrals
(17) Post-exposure prophylaxis (PEP)
(18) Hepatitis testing/vaccination
(19) STD clinic
(20) Reproductive health services
(21) Other Non-HIV medical services
(22) Social services
(23) Other, specify _____

Counselor: Review/Assess Introductory Issues
 Anonymity/confidentiality/non-names testing.
 Risk assessment process and purpose of form.
 What the HIV test measures.
 Meaning/accuracy of test results (preliminary positive, positive, negative, inconclusive).
 Impact of HIV on the immune system.

Counselor: Review/Assess Testing Issues
 Window period/date of any follow-up test.
 Process of testing.
 Coping with waiting for test results.
 Client's readiness to be tested.
 Offer testing, if appropriate.
 Encourage the client to return for results.

Counselor Notes:

CHS 8458 (9/03)

Thumbnail of the HIV Counseling Information Form, showing the back side with various checkboxes and text fields. The form includes sections for 'Client Information', 'HIV Testing History', 'Referrals', and 'Counselor Notes'. It also features a table for tracking referrals and a section for 'Counselor: Review/Assess Introductory Issues' and 'Counselor: Review/Assess Testing Issues'. The form is titled 'HIV COUNSELING INFORMATION FORM' and includes the text 'State of California—Health and Human Services Agency' and 'Department of Health Services'.

HIV6 CIF *(front side)*

**Unique Office of AIDS
Client Number**

- Required for data reporting and payment.
- Never use the same number.

DIFFERENT TYPES OF STICKERS:

- White stickers for risk assessment only.
- Purple stickers from HIV Antibody Lab slip.
- Yellow stickers are available

HIV6 CIF (front side)

Administrative Information

Agency/
LHD no.: **1** **5**

Site no.: **1**

Clinic type: (mark one)

- (1) Alternative test site
- (2) Family planning
- (3) STD clinic
- (4) Alc./drug treatment
- (5) Detention facility
- (6) Primary care/CHC
- (7) HIV test
- (8) Street outreach
- (9) Mobile van
- (10) TB clinic
- (11) Youth drop in
- (12) Other health department
- (13) Other, specify: _____

Client's test election: (mark one)

- (1) Tested anonymously
- (2) Tested confidentially
- (3) Declined testing/not tested

- (09) Mobile van
- (10) TB
- (11) Youth drop in
- (12) Other health dept.
- (13) Other, specify: _____
- (09) No, Does NOT want to know
- (10) No, Other reason
- (11) Test not offered

(mark one)
anonymously
confidentially
other non-OA test

ntly
dow period
th confidentiality
not convenient

HIV6 CIF (front side)

Counseling Dates

(date and initial)

Service Date (mm/dd/yy)

Initials (print)

Risk assessment:

0	1	2	5	0	4
---	---	---	---	---	---

	D	S	W
--	---	---	---

Follow-up contact:

--	--	--	--	--	--

--	--	--	--

(to reset missed disclosure/post disclosure sessions by confidential clients)

Disclosure session:

0	1	2	5	0	4
---	---	---	---	---	---

	D	S	W
--	---	---	---

(this may be the same date as risk assessment for rapid test results)
(carefully verify anonymous clients using *Client Information*)

(1) Mark if post disclosure counseling scheduled.

Post disclosure session:

0	2	0	5	0	4
---	---	---	---	---	---

	D	S	W
--	---	---	---

(for rapid test positive confirmatory disclosures and post disclosure)
(carefully verify anonymous clients using *Client Information*)

Follow-up contact may be a phone call or attempt to reach confidentially tested clients who fail to show up for result.

Counseling and Test Result		
Counseling: (date and initial)	Date Service Provided (mm/dd/yy)	Print Initials
Risk Assessment Counseling: _____	_____	_____
Follow-up Contact: _____	_____	_____
(to reset missed disclosure sessions by confidential patients)		
Disclosure Counseling: _____	_____	_____
<input type="checkbox"/> Mark <input checked="" type="checkbox"/> if post disclosure counseling scheduled.		
Post Disclosure Counseling: _____	_____	_____
Test result: (mark one <input checked="" type="checkbox"/> and initial)		Initials
<input type="checkbox"/> (1) Positive <input type="checkbox"/> (2) Negative <input type="checkbox"/> (3) Inconclusive		_____
(carefully verify anonymous clients using <i>Client Information</i>)		
<input type="checkbox"/> Mark <input checked="" type="checkbox"/> if oral test kit used. <input type="checkbox"/> Mark <input checked="" type="checkbox"/> if rapid test used.		

HIV6 CIF (front side)

First letter of last name:

W

*Enter first letter of last name.
Mark "*" if declined/refused.*

Alternative billing:

(mark all that apply ☒)

- (1) No billing to OA
- (1) Risk Assessment
- (1) Disclosure
- (1) Post Disclosure
- (1) Laboratory Work

Detuned: *(studies only)*

- (1) DTR (recent)
- (2) DTL (long standing)
- (3) DTNT (not tested)

Matching criterion:

Enter first letter of last name. Mark "*" if declined/refused.

First letter of last name:

Alternative billing:
(mark all that apply ☒)

- No billing to OA
- Risk Assessment
- Disclosure
- Post Disclosure
- Laboratory Work

HIV6 CIF (front side)

Client Information

Race/ethnicity: (mark one or two)

- | 1st | 2nd | |
|---|---|---------------------------------|
| <input checked="" type="checkbox"/> (1) | <input type="checkbox"/> (1) | African American (not Hispanic) |
| <input type="checkbox"/> (2) | <input type="checkbox"/> (2) | American Indian/Alaskan Native |
| <input type="checkbox"/> (3) | <input type="checkbox"/> (3) | Asian/Pacific Islander |
| <input type="checkbox"/> (4) | <input type="checkbox"/> (4) | Hispanic/Latino(a) |
| <input type="checkbox"/> (5) | <input checked="" type="checkbox"/> (5) | White (not Hispanic) |
| <input type="checkbox"/> (6) | <input type="checkbox"/> (6) | Other, specify: _____ |

Date of birth:
(mm/dd/yy)

0	1	2	5	6	4
---	---	---	---	---	---

If a client refuses to give DOB and only gives their age then calculate year of birth for example age 49 is entered 000054.

Client Information

Race/ethnicity: (mark one or two)

1st	2nd	
<input type="checkbox"/> (1)	<input type="checkbox"/> (1)	African American (not Hispanic)
<input type="checkbox"/> (2)	<input type="checkbox"/> (2)	American Indian/Alaskan Native
<input type="checkbox"/> (3)	<input type="checkbox"/> (3)	Asian/Pacific Islander
<input type="checkbox"/> (4)	<input type="checkbox"/> (4)	Hispanic/Latino(a)
<input type="checkbox"/> (5)	<input checked="" type="checkbox"/> (5)	White (not Hispanic)
<input type="checkbox"/> (6)	<input type="checkbox"/> (6)	Other, specify: _____

Date of birth: (mm/dd/yy)

HIV6 CIF (front side)

Gender and pregnancy: (mark one ☒)

- (1) Male
- (2) Female
- (3) Pregnant female
- (4) Transgendered: male to female
- (5) Transgendered: female to male
- (6) Other, specify: _____

Sexual orientation: (mark one ☒)

- (1) Heterosexual (straight)
- (2) Bisexual
- (3) Gay, lesbian, queer, or homosexual
- (4) Other, specify: _____
- (5) Client doesn't know

Gender and pregnancy: (mark one ☒)

- (1) Male
- (2) Female
- (3) Pregnant Female
- (4) Transgendered: Male to Female
- (5) Transgendered: Female to Male
- (6) Other, specify: _____

HIV6 CIF (front side)

Residence county: Sacramento/34

Residence zip code:

9	5	8	3	5
---	---	---	---	---

(1) Mark if client is homeless.

Residence county: _____
Residence zip code:

--	--	--	--	--

 Mark if client is homeless.

HIV6 CIF (front side)

Client was referred by: (mark one)

- (1) HIV+ partner
- (2) PCRS/partner notification
- (3) OA NIGHT outreach (incentive/referral)
- (4) Other outreach worker
- (5) HIV education program
- (6) AIDS telephone hotline
- (7) Other AIDS agency
- (8) Alcohol/drug treatment program
- (9) M.D./health clinic
- (10) Friend/relative
- (11) Media (TV, radio, print)
- (12) Internet
- (13) No identifiable referral source



Enter the lowest number or highest listed item if multiple referrals are given

- Client was referred by: (mark one)
- (01) HIV+ partner
 - (02) PCRS/partner notification
 - (03) OA NIGHT outreach (incentive/referral)
 - (04) Other outreach worker
 - (05) HIV education program
 - (06) AIDS telephone hotline
 - (07) Other AIDS agency
 - (08) Alcohol/drug treatment program
 - (09) M.D./health clinic
 - (10) Friend/relative
 - (11) Media (TV, radio, print)
 - (12) No identifiable referral source

HIV6 CIF (front side)

Client's reason for testing: (mark one ☒)

- (1) Reconfirming HIV+ result
- (2) Reports AIDS-like symptoms
- (3) Has current HIV+ partner
- (4) Had past HIV+ partner
- (5) TB diagnosis
- (6) STD related
- (7) Hepatitis diagnosis
- (8) Pregnancy
- (9) Risky behavior
- (10) Starting a new relationship
- (11) Partner request
- (12) Rape/assault
- (13) Exposure to blood
- (14) Immigration
- (15) Other, specify: _____



Enter the lowest number or highest listed item if multiple reasons are given

- Client's reason for testing:** (mark one ☒)
- (01) Reconfirming HIV+ result
 - (02) Reports AIDS-like symptoms
 - (03) Has current HIV+ partner
 - (04) Had past HIV+ partner
 - (05) TB diagnosis
 - (06) STD related
 - (07) Pregnancy
 - (08) Risky behavior
 - (09) Starting a new relationship
 - (10) Just wanted to know
 - (11) Other, specify: _____

HIV6 CIF (front side)

HIV Testing History

Number of prior HIV tests: (circle one)

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9+)

Date of last test result: (mm/yy)

0	1	0	2
---	---	---	---

Last test result: (mark one)

- (1) Positive
- (2) Negative
- (3) Inconclusive
- (4) Did not return for results

HIV Testing History

Number of prior HIV tests: (circle one)

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9+)

Date of last test result: ____/____ (mm/yy)

Last test result: (mark one)

- (1) Positive
- (2) Negative
- (3) Inconclusive
- (4) Did not return for results

HIV6 CIF (front side)

Risk Reduction Steps

Using condoms with partners

Risk assessment stage of change: (mark one)

- (1) Not thinking about it (Precontemplation)
- (2) Thinking about it (Contemplation)
- (3) Ready for action (Preparation)
- (4) Action
- (5) Maintenance

Immediate risk reduction step:

(to be accomplished by client before disclosure)

Purchase condoms and practice using them.

At disclosure: risk reduction step(s): (mark one)

- (1) No step established at risk assessment
- (2) Client made no effort
- (3) Step attempted
- (4) Step achieved

Post disclosure/short-term risk reduction step(s):

Discuss using condoms for anal sex with

partners of unknown status.

Long-term risk reduction step(s):

Use condoms for anal sex with secondary

partners.

Risk Reduction Goals

Risk assessment stage of change: (mark one)

- (1) Not thinking about it (Precontemplation)
- (2) Thinking about it (Contemplation)
- (3) Ready for action (Preparation)
- (4) Action
- (5) Maintenance

Immediate risk reduction goal setting:
(to be accomplished by client before disclosure)

At Disclosure: Risk reduction goal(s): (mark one)

- (1) No Goal Established at Risk Assessment
- (2) Client Made No Effort
- (3) Goal Attempted
- (4) Goal Achieved

Post Disclosure/Short term risk reduction goal(s):

Long term risk reduction goal(s):

HIV6 CIF (front side)

Referrals

Client referrals:
Record at risk assessment (RA), disclosure (D) and post disclosure (PD). Order by marking 1 for your primary referral. Other referrals should be numbered 2 and 3.

	RA	D	PD
(1) NONE			
(2) Referral list only			
(3) Other HIV testing			
Risk/harm reduction			
(4) Prevention case management (PCM)			
(5) HIV education & prevention services	1	1	
(6) Follow-up HIV counseling			
(7) Prevention skill development			
(8) Prevention support group			
(9) Individual psychotherapy/counseling		2	
Substance use services			
(10) Alcohol/drug treatment			
(11) Twelve step program	2		
(12) Needle exchange program			
HIV positive referrals			
(13) Early intervention program (EIP)			
(14) HIV case management			
(15) HIV medical care/evaluation/treatment			
(16) PCRS/partner notification			
Other referrals			
(17) Post-exposure prophylaxis (PEP)			
(18) Hepatitis testing/vaccination			
(19) STD clinic		3	
(20) Reproductive health services			
(21) Other Non-HIV medical services			
(22) Social services			
(23) Other, specify: _____			

Referrals

Client referrals:
Record at risk assessment (RA), disclosure (D) and post disclosure (PD). Order by marking 1 for your primary referral. Other referrals should be numbered 2 and 3.

RA	D	PD	
_____	_____	_____	(01) NONE
_____	_____	_____	(02) Referral list only
Other Testing			
_____	_____	_____	(03) CCS/HIV children's program
_____	_____	_____	(04) Other testing
Risk/Harm Reduction			
_____	_____	_____	(05) HIV education service
_____	_____	_____	(06) Follow-up HIV counseling
_____	_____	_____	(07) Prevention skill development
_____	_____	_____	(08) Prevention support group
_____	_____	_____	(09) Individual psychotherapy
_____	_____	_____	(10) Alcohol/drug treatment
_____	_____	_____	(11) Twelve step program
_____	_____	_____	(12) Needle exchange program
HIV Positive and Other Referrals			
_____	_____	_____	(13) EIP
_____	_____	_____	(14) Medical services
_____	_____	_____	(15) PCRS/partner notification
_____	_____	_____	(16) Case management
_____	_____	_____	(17) Crisis intervention
_____	_____	_____	(18) TB
Other Services			
_____	_____	_____	(19) STD clinic
_____	_____	_____	(20) Family planning clinic
_____	_____	_____	(21) Pregnancy evaluation/care
_____	_____	_____	(22) Social services
_____	_____	_____	(23) Domestic violence counseling
_____	_____	_____	(24) Other, specify: _____

HIV6 CIF (front side)

Counselor: Review/Assess Introductory Issues

- Anonymity/confidentiality/non-names testing.
- Risk assessment process and purpose of form.
- What the HIV test measures.
- Meaning/accuracy of test results
(preliminary positive, positive, negative, inconclusive).
- Impact of HIV on the immune system.

Counselor: Review/Assess Testing Issues

- Window period/date of any follow-up test.
- Process of testing.
- Coping with waiting for test results.
- Client's readiness to be tested.
- Offer testing, if appropriate.
- Encourage the client to return for results.

Counselor Notes:

Counselor: Review/Assess Introductory Issues

- Confidentiality/anonymity testing.
- Risk assessment process and purpose of form.
- What the HIV test measures.
- Meaning and accuracy of test results
(positive, negative, inconclusive).
- Impact of HIV on the immune system.

Counselor Notes:

Counselor: Review/Assess Testing Issues

- Window period/date of any follow-up test.
- Process of testing.
- Coping with waiting for test results.
- Client's readiness to be tested.
- Offer testing, if appropriate.
- Encourage the client to return for results.

HIV6 CIF (back side)

Discuss and record the client's behavior during the **fast two years** unless otherwise indicated. If client has received an HIV test result during the last two years then discuss and record the client's behavior since the date of the client's last test result.
 Date of last test result: (if within last 2 years) ____ / ____ / ____ (mm/yy) (from HIV Testing History on front of form)

Sexual Risk History (last 2 years/fast result)

Total number of sex partners: (last 2 years/fast result) (000-999)

Male sex partner(s).
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Female sex partner(s).
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive

Transgendered partner(s).
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Sex with sex worker(s)/prostitute(s).
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Sex partner(s) who injected drugs or other substances.
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

HIV-infected sex partner(s).
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Did client know partner's HIV-positive status prior to sexual contact? Yes No

(Females Only) Male partner(s) who has had sex with a male.
 Partners: (mark one) no partners one or more declined/refused
 Sexual activity: Yes No TFC Never Sometimes Always
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Optional Data
 Item 1: Item 3:
 Item 2: Item 4:

Counselor: Review/Assess Basic Issues
 Discuss safer sex guidelines. Demonstrate proper condom/barrier use.
 Role-play with client to build needed skills. Discuss obstacles to condom/barrier use.
 Partner risks as they relate to client risk. Cultural/peer influences.
 Risk reduction communication with partner. Domestic violence/sexual assault.
 Integration of birth control & risk reduction. Voluntary PCR/S-partner notification.
 Pregnancy/maternal transmission (sterc, fBFB, breastfeeding).

Substance Use History (last 2 years/fast result) declined/refused

Substance use: (mark all that apply) no alcohol or drug use
 alcohol marijuana (pot, grass, weed, hash)
 heroin, etc., (sm, snag, smack, H)
 barbiturate/tranquilizers crack (rock)
 amphetamine (crack, crystal, line)
 cocaine (powder)
 nitrate/nitrite (poppers, rush)
 ecstasy (MDMA, Adam, E, X)
 GHB (liquid ecstasy, ghna, G)
 ketamine (special K, K)
 Viagra (Sildenafil, Viagra, Cialis, Levitra)
 hallucinogens (LSD and others)
 other, specify: _____

Injection behaviors: (complete if injected)
 Never Sometimes Always TFC
 Shared needles Shared with a known HIV+ partner? Yes No
 Cleaned works Is NE available in client's area? Yes No
 Needle exchange

Needle/syringe sources: (mark all that apply)
 needle exchange program needle dealer/seller close friend
 secondary exchange shooting gallery sexual partner
 pharmacy/drug store diabetic other source

IDU treatment history: Never Currently in treatment Within last 2 yr/fast result Prior to last 2 yr/fast result

Other Risk History

STDs/hepatitis (last 2 years/fast result): (mark all that apply) declined/refused
 no STDs/hepatitis genital/anal warts (HPV)
 syphilis (syph, the pock, leso) genital herpes (HSV)
 gonorrhea urethral (GC, clap, drip) hepatitis A (HAV)
 gonorrhea oral (GC, clap, drip) hepatitis B (HBV)
 gonorrhea anal/rectal (GC, clap, drip) hepatitis C (HCV)
 chlamydia other, specify: _____
 trichomoniasis (trich)

Viral STDs/hepatitis (lifetime history): (mark all that apply) declined/refused
 no lifetime viral STDs/hepatitis hepatitis A (HAV)
 genital/anal warts (HPV) hepatitis B (HBV)
 genital herpes (HSV) hepatitis C (HCV)

Hepatitis vaccination (lifetime history): (mark one) declined/refused
 Completed vaccination series for hepatitis A (HAV)? Yes No declined/refused
 Completed vaccination series for hepatitis B (HBV)? Yes No declined/refused

Other risk factors (last 2 years/fast result): (mark one) declined/refused
 Received money/other items or services for sex. Yes No declined/refused
 Received drugs for sex. Yes No declined/refused
 Behavior resulting in other blood-to-blood contact (SM, tattooing, piercing, cuts, etc.) or that allows blood contact with mouth, vagina or anus. Yes No declined/refused
 Shared objects/fingers inserted in mouth, vagina or anus. Yes No declined/refused
 Blood-to-blood exposure on the job. Yes No declined/refused
 Job exposure blood known to be HIV+. Yes No declined/refused
 Blood/blood product transfusion before 1985 (or in a country where blood is/was not tested for HIV). Yes No declined/refused
 Child born of an HIV-infected woman. Yes No declined/refused
 Other behavior, specify: _____ Yes No declined/refused

Counselor: Review/Assess Drug and STD Issues
 Prevention/harm reduction/needle sets with IDUs. Demonstrate proper needle cleaning.
 Explore alcohol & drug treatment/recovery. Drugs with sex as co-factor for HIV risk.
 Behaviors affecting other STDs (eg, rimming). STDs as a co-factor for HIV risk.
 Health effects of concurrent STD/HIV (ie, pelvic inflammatory disease).

Time Frame Code (TFC): (check only) 6 = within past 6 months 1 = within past 12 months
 2 = within past 2 years ++ = greater than 2 yrs 0 = unknown * = declined/refused



HIV6 CIF (back side)

Discuss and record the client's behavior during the **last two years** unless otherwise indicated. If client has received an HIV test result during the last two years then discuss and record the client's behavior since the date of the client's last test result.

Date of last test result: (if within last 2 years) ____/____ (mm/yy) (from HIV Testing History on front of form)

HIV Testing History

Number of prior HIV tests: (circle one)

(0) (1) **(2)** (3) (4) (5) (6) (7) (8) (9+)

Date of last test result: (mm/yy)

0	1	0	2
---	---	---	---

Time Frame Code (TFC): (studies only) 6 = within past 6 months 1 = within past 12 months
2 = within past 2 years + = greater than 2 yrs 9 = unknown * = declined/refused

HIV6 CIF (back side)

Sexual Risk History (last 2 years/last result)

Total number of sex partners:
 (last 2 years/last result) (000-999)

Male sex partner(s).

Partner(s): (mark one ☒)	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input checked="" type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Female sex partner(s).

Partner(s): (mark one ☒)	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input checked="" type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Transgendered partner(s).

Partner(s): (mark one ☒)	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input checked="" type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Male sex partner(s).

Partner(s):
 (mark one ☒)
 (0) no partners
 (1) one or more
 (*) declined/refused

Sexual activity:
 (mark all that apply ☒)
 Oral
 Vaginal
 Anal insertive
 Anal receptive

Frequency of barrier use:
 Never Sometimes Always
 (1) (2) (3)
 (1) (2) (3)
 (1) (2) (3)
 (1) (2) (3)

HIV6 CIF (back side)

Sex with sex worker(s)/prostitute(s).							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input checked="" type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Sex partner(s) who injected drugs or other substances.							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input checked="" type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

HIV-infected sex partner(s).							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input checked="" type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input checked="" type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Did client know partner's HIV-positive status prior to sexual contact?	
Yes	No
<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)

(Females Only) Male partner(s) who has had sex with a male.							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Sex with sex worker(s)/prostitute(s).							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Sex partner(s) who injected drugs or other substances.							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

HIV infected sex partner(s).							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal insertive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

Mark if client knew partner's HIV positive status prior to sexual contact.

(Females Only) Male partner(s) who has had sex with a male.							
Partner(s): <i>(mark one ☒)</i>	Sexual activity:			TFC	Frequency of barrier use:		
	Yes	No			Never	Sometimes	Always
<input type="checkbox"/> (0) no partners	Oral	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (1) one or more	Vaginal	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<input type="checkbox"/> (*) declined/refused	Anal receptive	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

HIV6 CIF (back side)

Substance Use History (last 2 years/last result) (*) declined/refused

Substance use: (mark all that apply <input checked="" type="checkbox"/>)	TFC	Injected:		Frequency used with sex:			
		Yes	No	Never	Rarely	Sometimes	Usually
<input type="checkbox"/> (1) no alcohol or drug use							
<input checked="" type="checkbox"/> (1) alcohol		<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input checked="" type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input checked="" type="checkbox"/> (1) marijuana (pot, grass, weed, hash)				<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) heroin, etc. (junk, skag, smack, H)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) barbiturate/tranquilizers		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) crack (rock)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input checked="" type="checkbox"/> (1) amphetamine (crank, crystal, tina)		<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input checked="" type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) cocaine (powder)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) nitrate/nitrite (poppers, rush)				<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) ecstasy (MDMA, Adam, E, X)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) GHB (liquid ecstasy, gina, G)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) ketamine (special K, K)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) Viagra (Cialis, Levitra, Meltabs, Caverta, Generic - Viagra, Cialis, & Levitra)				<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) hallucinogens (LSD, acid, psilocybin, peyote, mescaline, PCP)		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) other, specify: _____		<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)

Drug and Substance Use History (last 2 years/last result)

(*) declined/refused

Drugs & substances used: (mark all that apply <input checked="" type="checkbox"/>)	Injected: (mark if yes)	Frequency used with sex:			
		Never	Rarely	Sometimes	Usually
<input type="checkbox"/> alcohol	<input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> marijuana	<input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> heroin, etc.	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> barbiturate	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> tranquilizers	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> crack	<input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> amphetamine	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> cocaine	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> nitrate/nitrite	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> ecstasy	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> PCP	<input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> hallucinogens	<input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> other, specify: _____	<input type="checkbox"/> (1) yes <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)

HIV6 CIF (back side)

Injection behaviors: (complete if injected)

	Never	Sometimes	Always	TFC		Yes	No
Shared needles	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (2)	<input type="checkbox"/> (3)		Shared with a known HIV+ partner?	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)
Cleaned works	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)				
Needle exchange	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)		Is NE available in client's area?	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)

Needle/syringe sources: (mark all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> (1) needle exchange program | <input type="checkbox"/> (1) needle dealer/seller | <input checked="" type="checkbox"/> (1) close friend |
| <input checked="" type="checkbox"/> (1) secondary exchange | <input checked="" type="checkbox"/> (1) shooting gallery | <input type="checkbox"/> (1) sexual partner |
| <input type="checkbox"/> (1) pharmacy/drug store | <input type="checkbox"/> (1) diabetic | <input type="checkbox"/> (1) other source |

IDU treatment history	Never	Currently in treatment	Within last 2 yrs/last result	Prior to last 2 yrs/last result	TFC
	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)	

Injected drugs or other substances.

Shared needles: (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Never <input type="checkbox"/> (2) Sometimes <input type="checkbox"/> (3) Always <input type="checkbox"/> Mark <input checked="" type="checkbox"/> if shared needles with a known HIV positive partner.	Needle exchange: (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Never <input type="checkbox"/> (2) Sometimes <input type="checkbox"/> (3) Always <input type="checkbox"/> (4) Not available in client's area
Cleaned works: (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Never <input type="checkbox"/> (2) Sometimes <input type="checkbox"/> (3) Always	IDU treatment history: (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Never <input type="checkbox"/> (2) Within last 2 years/last result <input type="checkbox"/> (3) Prior to last 2 years/last result

HIV6 CIF (back side)

Other Risk History

STDs/hepatitis (last 2 years/last result): (mark all that apply) (*) declined/refused

- | | |
|---|---|
| <input type="checkbox"/> (1) no STDs/hepatitis | <input type="checkbox"/> (1) genital/anal warts (HPV) |
| <input checked="" type="checkbox"/> (1) syphilis (<i>syph, the pox, lues</i>) | <input type="checkbox"/> (1) genital herpes (HSV) |
| <input type="checkbox"/> (1) gonorrhea urethral (<i>GC, clap, drip</i>) | <input type="checkbox"/> (1) hepatitis A (HAV) |
| <input type="checkbox"/> (1) gonorrhea oral (<i>GC, clap, drip</i>) | <input checked="" type="checkbox"/> (1) hepatitis B (HBV) |
| <input type="checkbox"/> (1) gonorrhea anal/rectal (<i>GC, clap, drip</i>) | <input type="checkbox"/> (1) hepatitis C (HCV) |
| <input type="checkbox"/> (1) chlamydia | <input type="checkbox"/> (1) other, specify: _____ |
| <input type="checkbox"/> (1) trichomoniasis (<i>trich</i>) | |

Viral STDs/hepatitis (lifetime history): (mark all that apply) (*) declined/refused

- | | |
|---|---|
| <input type="checkbox"/> (1) no lifetime viral STDs/hepatitis | <input checked="" type="checkbox"/> (1) hepatitis A (HAV) |
| <input type="checkbox"/> (1) genital/anal warts (HPV) | <input checked="" type="checkbox"/> (1) hepatitis B (HBV) |
| <input type="checkbox"/> (1) genital herpes (HSV) | <input type="checkbox"/> (1) hepatitis C (HCV) |

Other Risk History (last 2 years/last result)	
Hepatitis and STD History.	<input type="checkbox"/> (*) declined/refused
STDs/Hepatitis : (mark all that apply <input checked="" type="checkbox"/>)	
<input type="checkbox"/> no STDs/Hepatitis	<input type="checkbox"/> genital/anal warts (HPV)
<input type="checkbox"/> syphilis (<i>syph, the pox, lues</i>)	<input type="checkbox"/> genital herpes (HSV)
<input type="checkbox"/> gonorrhea (<i>GC, clap, drip</i>)	<input type="checkbox"/> hepatitis B (HBV)
<input type="checkbox"/> chlamydia	<input type="checkbox"/> hepatitis C (HCV)
<input type="checkbox"/> trichomoniasis (<i>trich</i>)	<input type="checkbox"/> other, specify: _____

HIV6 CIF *(back side)*



Hepatitis vaccination (<i>lifetime history</i>): (mark one each ☒)	Yes	No	<i>declined/ refused</i>
Completed vaccination series for hepatitis A (HAV)?	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Completed vaccination series for hepatitis B (HBV)?	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (*)

HIV6 CIF (back side)

Other risk factors (last 2 years/last result): (mark one each <input checked="" type="checkbox"/>)	Yes	No	declined/ refused
Received money/other items or services for sex.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input checked="" type="checkbox"/> (*)
Received drugs for sex.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input checked="" type="checkbox"/> (*)
Behavior resulting in other blood-to-blood contact (SM, tattooing, piercing, cuts, etc.) or that allows blood contact with mouth, vagina or anus.	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Shared objects/fingers inserted in mouth, vagina or anus.	<input checked="" type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (*)
Blood-to-blood exposure on the job.	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Job exposure blood known to be HIV+.	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Blood/blood product transfusion before 1985 (or in a country where blood is/was not tested for HIV).	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Child born of an HIV-infected woman.	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)
Other behavior, specify: _____	<input type="checkbox"/> (1)	<input checked="" type="checkbox"/> (0)	<input type="checkbox"/> (*)

Other risk factors. (mark <input checked="" type="checkbox"/> , if appropriate)	Declined/refused
<input type="checkbox"/> Received money/other items or services for sex.	<input type="checkbox"/> (*)
<input type="checkbox"/> Received drugs for sex.	<input type="checkbox"/> (*)
<input type="checkbox"/> Behavior resulting in other blood to blood contact (SM, tattooing, piercing, cuts, etc.) or that allows blood contact with mouth, vagina or anus.	<input type="checkbox"/> (*)
<input type="checkbox"/> Shared objects/fingers inserted in mouth, vagina or anus.	<input type="checkbox"/> (*)
<input type="checkbox"/> Blood to blood exposure on the job.	<input type="checkbox"/> (*)
<input type="checkbox"/> Job exposure blood known to be HIV+.	<input type="checkbox"/> (*)
<input type="checkbox"/> Blood/blood product transfusion before 1985 (or in a country where blood is/was not tested for HIV).	<input type="checkbox"/> (*)
<input type="checkbox"/> Child born of an HIV-infected woman.	<input type="checkbox"/> (*)
<input type="checkbox"/> Other behavior, specify: _____	

HIV6 CIF *(back side)*

Optional Data

Item 1:	Item 3:
Item 2:	Item 4:

Optional Data	
Item 1:	_____
Item 2:	_____
Item 3:	_____
Item 4:	_____

HIV6 CIF (back side)

Counselor: Review/Assess Basic Issues

- | | |
|---|---|
| <input type="checkbox"/> Discuss safer sex guidelines. | <input type="checkbox"/> Demonstrate proper condom/barrier use. |
| <input type="checkbox"/> Role-play with client to build needed skills. | <input type="checkbox"/> Discuss obstacles to condom/barrier use. |
| <input type="checkbox"/> Partner risks as they relate to client risk. | <input type="checkbox"/> Cultural/peer influences. |
| <input type="checkbox"/> Risk reduction communication with partner. | <input type="checkbox"/> Domestic violence/sexual assault. |
| <input type="checkbox"/> Integration of birth control & risk reduction. | <input type="checkbox"/> Voluntary PCRS/partner notification. |
| <input type="checkbox"/> Pregnancy/maternal transmission (<i>utero, birth, breastfeed</i>). | |

Counselor: Review/Assess Drug and STD Issues

- | | |
|---|--|
| <input type="checkbox"/> Prevention/harm reduction/safer sex with IDUs. | <input type="checkbox"/> Demonstrate proper needle cleaning. |
| <input type="checkbox"/> Explore alcohol & drug treatment/recovery. | <input type="checkbox"/> Drugs with sex as co-factor for HIV risk. |
| <input type="checkbox"/> Behaviors affecting other STDs (eg. rimming). | <input type="checkbox"/> STDs as a co-factor for HIV risk. |
| <input type="checkbox"/> Health effects of concurrent STD/HIV (e.g. pelvic inflammatory disease). | |

Counselor: Review/Assess Drug and STD Issues

- Prevention/harm reduction/safer sex with IDUs.
- Demonstrate proper needle cleaning.
- Encourage and support substance abuse treatment and recovery.
- Alcohol/drug use with sex as co-factor for HIV risk.
- Other sexual behaviors affecting STDs (eg. rimming).
- Presence of STDs as a co-factor for HIV risk.
- Health effects of concurrent STD/HIV (e.g. pelvic inflammatory disease).

Counselor: Review/Assess Basic Issues

- Cultural/peer influences.
- Demonstrate proper condom & barrier use.
- Role-play with client to build needed skills.
- Discuss safer sex guidelines.
- Partner risks as they relate to client risk.
- Communication of HIV risk reduction with partner.
- Domestic violence/sexual assault.
- Voluntary PCRS/partner notification.
- Discuss obstacles to condom/barrier use.
- Pregnancy/maternal transmission (*utero, birth, breastfeed*).
- Integration of birth control and risk reduction.

HIV Antibody Test LRF

HIV ANTIBODY TEST		Unique Office of AIDS Client Number ▶	 999-9999-9	ATTACH LABEL TO REPORT FORM AND BLOOD SPECIMEN
CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES		LOCAL LABORATORY NUMBER		
SPECIMEN DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i> RETURN APPOINTMENT DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i> GENDER: <input type="checkbox"/> (1) MALE <input type="checkbox"/> (2) FEMALE <input type="checkbox"/> (3) M-F <input type="checkbox"/> (4) F-M DATE OF BIRTH: <input type="text"/> <input type="text"/> <i>(mm/dd/yyyy)</i> RESIDENCE COUNTY: _____ RESIDENCE ZIP CODE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		LABORATORY NAME & ADDRESS: _____ _____ _____ CLINIC/SITE NAME, ADDRESS, & PHONE: _____ _____ _____		
CONFIDENTIAL TESTING USE ONLY				
LAST NAME: _____ SSN: <i>(last 4 digits, 0000 if unknown)</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SOUNDEX CODE: <input type="text"/> <input type="text"/> <input type="text"/>				
RAPID TEST USE ONLY				
LOT NUMBER: <input type="text"/> <input type="text"/> EXPIRATION DATE: <i>(mm/yy)</i> <input type="text"/> <input type="text"/> COUNSELOR/TECH INITIALS: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE				
BEGIN TEST		END TEST		
TIME	TEMPERATURE	TIME	TEMPERATURE	
<input type="checkbox"/> AM <input type="checkbox"/> PM	° F	<input type="checkbox"/> AM <input type="checkbox"/> PM	° F	
RESULT: <input type="checkbox"/> (1) PRELIMINARY POSITIVE <i>(indicate confirmatory specimen)</i> <input type="checkbox"/> (2) NEGATIVE <input type="checkbox"/> (3) INVALID, reason: _____				
CONFIRMATORY SPECIMEN GIVEN: <input type="checkbox"/> (1) YES <input type="checkbox"/> (2) NO				
LAB SPECIMEN				
SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE				
DATE RECEIVED BY LAB: <i>(mm/dd/yy)</i> _____		DATE REPORTED: <i>(mm/dd/yy)</i> _____		
ELISA: <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (2) NON-REACTIVE SUPPLEMENTAL TEST PERFORMED: <input type="checkbox"/> (1) IFA <input type="checkbox"/> (1) WESTERN BLOT <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (2) NON-REACTIVE <input type="checkbox"/> (2) NON-REACTIVE <input type="checkbox"/> (3) NONSPECIFIC/ UNSATISFACTORY <input type="checkbox"/> (3) INDETERMINATE				
SUMMARY INTERPRETATION: <input type="checkbox"/> (1) HIV ANTIBODY DETECTED <input type="checkbox"/> (2) NO HIV ANTIBODY DETECTED <input type="checkbox"/> (3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN <input type="checkbox"/> SEE ENCLOSED NOTE				
NOTE: _____				
ATTACH LABEL TO REPORT FORM AND BLOOD SPECIMEN				
999-9999-9 999-9999-9 999-9999-9 999-9999-9 999-9999-9 999-9999-9 999-9999-9 999-9999-9 999-9999-9				
SEND REMAINING LABELS WITH COPIES 1, 2, & 3 OF FORM TO THE LABORATORY				

LABORATORY COPY

DHS 8257 (9/03)

HIV Antibody Test LRF

SPECIMEN DATE:
(mm/dd/yy)

0	1	0	9	0	4
---	---	---	---	---	---

RETURN APPOINTMENT DATE:
(mm/dd/yy)

0	1	2	2	0	4
---	---	---	---	---	---

GENDER: (1) MALE (2) FEMALE (3) M-F (4) F-M

DATE OF BIRTH:
(mm/dd/yyyy)

0	4	2	9	1	9	7	0
---	---	---	---	---	---	---	---

RESIDENCE COUNTY: 38

RESIDENCE ZIP CODE:

9	5	8	1	4
---	---	---	---	---

HIV Antibody Test LRF

CONFIDENTIAL TESTING USE ONLY

LAST NAME: SmithJones

SSN: *(last 4 digits,
0000 if unknown)*

4	9	4	3
---	---	---	---

SOUNDEX CODE:

--	--	--	--

HIV Antibody Test LRF

RAPID TEST USE ONLY

LOT NUMBER:

9	6	7	2	1	4	5	2
---	---	---	---	---	---	---	---

EXPIRATION DATE:(mm/yy)

0	4	0	4
---	---	---	---

 COUNSELOR/TECH INITIALS:

	S	C	W
--	---	---	---

SPECIMEN: (1) ORAL (2) FINGER STICK (3) VENIPUNCTURE

BEGIN TEST		END TEST	
TIME	TEMPERATURE	TIME	TEMPERATURE
9:30 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	76 ° F	9:53 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	76 ° F

RESULT: (1) PRELIMINARY POSITIVE (*indicate confirmatory specimen*)
 (2) NEGATIVE
 (3) INVALID, reason: _____

CONFIRMATORY SPECIMEN GIVEN: (1) YES (2) NO

HIV Antibody Test LRF

LAB SPECIMEN

SPECIMEN: (1) ORAL (2) FINGER STICK (3) VENIPUNCTURE

HIV Antibody Test LRF

LABORATORY NAME & ADDRESS:

CLINIC/SITE NAME, ADDRESS, & PHONE:

HIV Antibody Test LRF

LABORATORY USE ONLY

ELISA: (1) REACTIVE (2) NON-REACTIVE

SUPPLEMENTAL TEST PERFORMED:

(1) IFA

(1) REACTIVE

(2) NON-REACTIVE

(3) NONSPECIFIC/
UNSATISFACTORY

(1) WESTERN BLOT

(1) REACTIVE

(2) NON-REACTIVE

(3) INDETERMINATE

SUMMARY INTERPRETATION:

(1) HIV ANTIBODY DETECTED

(2) NO HIV ANTIBODY DETECTED

(3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN

SEE ENCLOSED NOTE

NOTE: _____

DATE RECEIVED

BY LAB: (mm/dd/yy) _____

DATE REPORTED:

(mm/dd/yy) _____

HIV Antibody Test LRF

Recording Multiple Tests:

- OA Number on the CIF must match the OA number on the final test result lab slip
- Circumstance that require multiple tests:
 - Invalid rapid test
 - Discordant confirmatory test
 - Standard inconclusive test

HIV Antibody Test LRF

HIV ANTIBODY TEST		Unique Office of AIDS Client Number ▶	 999-9999-9
CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES		LOCAL LABORATORY NUMBER	
SPECIMEN DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i>		LABORATORY NAME & ADDRESS: _____ _____ _____ _____ _____ CLINIC/SITE NAME, ADDRESS, & PHONE: _____ _____ _____ _____ _____	
RETURN APPOINTMENT DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i>			
GENDER: <input type="checkbox"/> (1) MALE <input type="checkbox"/> (2) FEMALE <input type="checkbox"/> (3) M-F <input type="checkbox"/> (4) F-M			
DATE OF BIRTH: <input type="text"/> <input type="text"/> <i>(mm/dd/yyyy)</i>			
RESIDENCE COUNTY: _____ RESIDENCE ZIP CODE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
CONFIDENTIAL TESTING USE ONLY			
LAST NAME: _____ SSN: <i>(last 4 digits, 0000 if unknown)</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SOUNDEX CODE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
RAPID TEST USE ONLY			
LOT NUMBER: <input type="text"/>			
EXPIRATION DATE: <i>(mm/yy)</i> <input type="text"/> <input type="text"/>		COUNSELOR/TECH INITIALS: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE			
BEGIN TEST		END TEST	
TIME	TEMPERATURE	TIME	TEMPERATURE
<input type="checkbox"/> AM <input type="checkbox"/> PM	° F	<input type="checkbox"/> AM <input type="checkbox"/> PM	° F
RESULT: <input type="checkbox"/> (1) PRELIMINARY POSITIVE <i>(indicate confirmatory specimen)</i> <input type="checkbox"/> (2) NEGATIVE <input type="checkbox"/> (3) INVALID, reason: _____			
CONFIRMATORY SPECIMEN GIVEN: <input type="checkbox"/> (1) YES <input type="checkbox"/> (2) NO			
LAB SPECIMEN			
SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE			
		ELISA: <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (2) NON-REACTIVE SUPPLEMENTAL TEST PERFORMED: <input type="checkbox"/> (1) IFA <input type="checkbox"/> (1) WESTERN BLOT <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (2) NON-REACTIVE <input type="checkbox"/> (2) NON-REACTIVE <input type="checkbox"/> (3) NONSPECIFIC/UNSATISFACTORY <input type="checkbox"/> (3) INDETERMINATE	
		SUMMARY INTERPRETATION: <input type="checkbox"/> (1) HIV ANTIBODY DETECTED <input type="checkbox"/> (2) NO HIV ANTIBODY DETECTED <input type="checkbox"/> (3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN <input type="checkbox"/> SEE ENCLOSED NOTE	
		NOTE: _____ _____ _____	
		DATE RECEIVED BY LAB: <i>(mm/dd/yy)</i> _____ DATE REPORTED: <i>(mm/dd/yy)</i> _____	

RETURN THIS COPY TO TEST SITE

HIV Antibody Test LRF

HIV ANTIBODY TEST		Unique Office of AIDS Client Number ▶		 999-9999-9
CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES				
SPECIMEN DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i>				
RETURN APPOINTMENT DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/dd/yy)</i>				
LABORATORY USE ONLY				
ELISA: <input type="checkbox"/> (1) REACTIVE <input type="checkbox"/> (2) NON-REACTIVE				
SUPPLEMENTAL TEST PERFORMED:				
<input type="checkbox"/> (1) IFA		<input type="checkbox"/> (1) WESTERN BLOT		
<input type="checkbox"/> (1) REACTIVE		<input type="checkbox"/> (1) REACTIVE		
<input type="checkbox"/> (2) NON-REACTIVE		<input type="checkbox"/> (2) NON-REACTIVE		
<input type="checkbox"/> (3) NONSPECIFIC/ UNSATISFACTORY		<input type="checkbox"/> (3) INDETERMINATE		
SUMMARY INTERPRETATION:				
<input type="checkbox"/> (1) HIV ANTIBODY DETECTED				
<input type="checkbox"/> (2) NO HIV ANTIBODY DETECTED				
<input type="checkbox"/> (3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN				
RAPID TEST USE ONLY				
LOT NUMBER: <input type="text"/>				
EXPIRATION DATE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>(mm/yy)</i>		COUNSELOR/ TECH INITIALS: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE				
BEGIN TEST		END TEST		
TIME	TEMPERATURE	TIME	TEMPERATURE	
<input type="checkbox"/> AM <input type="checkbox"/> PM	° F	<input type="checkbox"/> AM <input type="checkbox"/> PM	° F	
RESULT: <input type="checkbox"/> (1) PRELIMINARY POSITIVE <i>(indicate confirmatory specimen)</i>				
<input type="checkbox"/> (2) NEGATIVE				
<input type="checkbox"/> (3) INVALID, reason: _____				
CONFIRMATORY SPECIMEN GIVEN: <input type="checkbox"/> (1) YES <input type="checkbox"/> (2) NO				
LAB SPECIMEN				
SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE				

RETURN THIS COPY TO TEST SITE (data entry copy)

DHS 8257 (9/03)

HIV Antibody Test LRF

<p>HIV ANTIBODY TEST</p> <p>CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES</p>	<p>LOCAL LABORATORY NUMBER</p>	<p>Unique Office of AIDS Client Number ▶</p>	 <p>999-9999-9</p>
<p>SPECIMEN DATE: <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <i>(mm/dd/yy)</i></p> <p>RETURN APPOINTMENT DATE: <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <i>(mm/dd/yy)</i></p> <p>GENDER: <input type="checkbox"/> (1) MALE <input type="checkbox"/> (2) FEMALE <input type="checkbox"/> (3) M-F <input type="checkbox"/> (4) F-M</p> <p>DATE OF BIRTH: <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <i>(mm/dd/yyyy)</i></p> <p>RESIDENCE COUNTY: _____</p> <p>RESIDENCE ZIP CODE: <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p>	<p>LABORATORY NAME & ADDRESS:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>CLINIC/SITE NAME, ADDRESS, & PHONE:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>CONFIDENTIAL TESTING USE ONLY</p>			
<p>LAST NAME: _____</p> <p>SSN: <i>(last 4 digits, 0000 if unknown)</i> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>SOUNDEX CODE: <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p>			
<p>RAPID TEST USE ONLY</p>			
<p>LOT NUMBER: <input type="text"/><input type="text"/></p> <p>EXPIRATION DATE: <i>(mm/yy)</i> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> COUNSELOR/TECH INITIALS: <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE</p>			
<p>BEGIN TEST</p>		<p>END TEST</p>	
<p>TIME</p>	<p>TEMPERATURE</p>	<p>TIME</p>	<p>TEMPERATURE</p>
<p><input type="checkbox"/> AM <input type="checkbox"/> PM</p>	<p>° F</p>	<p><input type="checkbox"/> AM <input type="checkbox"/> PM</p>	<p>° F</p>
<p>RESULT: <input type="checkbox"/> (1) PRELIMINARY POSITIVE <i>(indicate confirmatory specimen)</i> <input type="checkbox"/> (2) NEGATIVE <input type="checkbox"/> (3) INVALID, reason: _____</p> <p>CONFIRMATORY SPECIMEN GIVEN: <input type="checkbox"/> (1) YES <input type="checkbox"/> (2) NO</p>			
<p>LAB SPECIMEN</p>			
<p>SPECIMEN: <input type="checkbox"/> (1) ORAL <input type="checkbox"/> (2) FINGER STICK <input type="checkbox"/> (3) VENIPUNCTURE</p>			

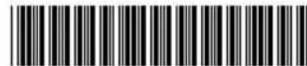
TEST SITE COPY

DHS 8257 (9/03)

HIV Antibody Test LRF

CALIFORNIA STATE DEPARTMENT
OF HEALTH SERVICES

Unique
Client
Number ▶



999-9999-9

SPECIMEN DATE:
(mm/dd/yy)

RETURN APPOINTMENT
DATE: *(mm/dd/yy)*

**YOU MUST BRING THIS SLIP
WITH YOU ON YOUR RETURN
APPOINTMENT DATE**

CLINIC/SITE NAME, ADDRESS, & PHONE:

CLIENT COPY

DHS 8257 (9/03)



Any Questions?

