

HEALTH CARE HIV TEST FORM

Unique ID: <input type="text"/>	Session date: <input type="text"/> <small>(mm/dd/yyyy)</small>	Provider ID: <input type="text"/>
Agency ID: <input type="text"/>	Intervention ID: <input type="text"/>	Location ID: <input type="text"/>

CLIENT INFORMATION

<p>Current gender identity: <i>(mark one ☒)</i></p> <p><input type="checkbox"/> (1) Male</p> <p><input type="checkbox"/> (2) Female</p> <p><input type="checkbox"/> (3) Transgender: male to female</p> <p><input type="checkbox"/> (4) Transgender: female to male</p> <p><input type="checkbox"/> (5) Other identity, specify: _____</p> <p><input type="checkbox"/> (6) Declined to answer</p> <p>Biological sex at birth: <i>(mark one ☒)</i></p> <p><input type="checkbox"/> (1) Male</p> <p><input type="checkbox"/> (2) Female</p> <p><input type="checkbox"/> (3) Intersex</p> <p><input type="checkbox"/> (4) Declined to answer</p> <p>Race/ethnicity: <i>(mark all that apply ☒)</i></p> <p><input type="checkbox"/> (1) Black/African American</p> <p><input type="checkbox"/> (1) American Indian/Alaska Native</p> <p><input type="checkbox"/> (1) Asian, specify: _____</p> <p><input type="checkbox"/> (1) Native Hawaiian/Pacific Islander, specify: _____</p> <p><input type="checkbox"/> (1) Hispanic/Latino(a), specify: _____</p> <p><input type="checkbox"/> (1) White</p> <p><input type="checkbox"/> (1) Client does not know</p> <p><input type="checkbox"/> (1) Declined to answer</p> <p>Date of birth: <i>(mm/dd/yyyy)</i></p> <input type="text"/>	<p>First letter of last name: <input type="text"/></p> <p>Residence County: _____</p> <p>Res. State: <input type="text"/> Residence ZIP code: <input type="text"/></p> <p>Housing status: <i>(currently)</i></p> <p><input type="checkbox"/> (1) Homeless <input type="checkbox"/> (1) Homeless</p> <p><input type="checkbox"/> (2) Unstably housed <input type="checkbox"/> (2) Unstably housed</p> <p><input type="checkbox"/> (3) Stably housed <input type="checkbox"/> (3) Stably housed</p> <p><input type="checkbox"/> (9) Declined to answer <input type="checkbox"/> (9) Declined to answer</p> <p>Health insurance coverage: <i>(mark all that apply ☒)</i></p> <p><input type="checkbox"/> (1) No coverage <input type="checkbox"/> (1) Private <input type="checkbox"/> (1) Medi-Cal (Medicaid)</p> <p><input type="checkbox"/> (1) Family PACT <input type="checkbox"/> (1) Low Income Health Program (LIHP)</p> <p><input type="checkbox"/> (1) Medicare <input type="checkbox"/> (1) Military <input type="checkbox"/> (1) Indian Health Service</p> <p><input type="checkbox"/> (1) Other public, specify: _____</p> <p>HIV test before today? <i>(mark one ☒)</i></p> <p><input type="checkbox"/> (1) Yes <i>(indicate recent HIV result & date)</i></p> <p><input type="checkbox"/> (0) No</p> <p><input type="checkbox"/> (8) Client does not know</p> <p><input type="checkbox"/> (9) Declined to answer</p> <p>Most recent HIV result received: <i>(mark one ☒ if tested before today)</i></p> <p><input type="checkbox"/> (1) Negative</p> <p><input type="checkbox"/> (2) Positive</p> <p><input type="checkbox"/> (3) Preliminary positive <i>(no confirmatory result received)</i></p> <p><input type="checkbox"/> (4) Inconclusive, discordant, invalid</p> <p><input type="checkbox"/> (5) Client does not know</p> <p><input type="checkbox"/> (9) Declined to answer</p>	<p>Date of last HIV test result: <i>(mm/yyyy)</i></p> <input type="text"/>
		<p>Who was billed for the current HIV test? <i>(mark one ☒)</i></p> <p><input type="checkbox"/> (1) Office of AIDS (OA)</p> <p><input type="checkbox"/> (2) Clinic paid for the HIV test</p> <p><input type="checkbox"/> (3) Client paid for the HIV test</p> <p><input type="checkbox"/> (4) Private</p> <p><input type="checkbox"/> (5) Medi-Cal (Medicaid)</p> <p><input type="checkbox"/> (6) Family PACT</p> <p><input type="checkbox"/> (7) Medicare</p> <p><input type="checkbox"/> (8) Military/Tricare</p> <p><input type="checkbox"/> (9) Indian Health Services</p> <p><input type="checkbox"/> (10) Other Public</p> <p>Received reimbursement for the HIV Test? <i>(mark one ☒)</i></p> <p><input type="checkbox"/> (1) Yes <i>(indicate reimbursement date)</i></p> <p>Reimbursement date: <i>(mm/dd/yyyy)</i></p> <input type="text"/> <p><input type="checkbox"/> (2) No, still waiting for reimbursement</p> <p><input type="checkbox"/> (3) No, the clinic will not be reimbursed</p>

HIV TEST INFORMATION

Test sequence:	HIV TEST #1	HIV TEST #2	HIV TEST #3
Test ID: <i>(optional)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sample date: <i>(mm/dd/yyyy)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider ID: <i>(optional)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Test technology: <i>(mark one ☒)</i>	<input type="checkbox"/> (1) Rapid <input type="checkbox"/> (2) Conventional <input type="checkbox"/> (3) NAAT/RNA <input type="checkbox"/> (4) Other test, specify: _____	<input type="checkbox"/> (1) Rapid <input type="checkbox"/> (2) Conventional <input type="checkbox"/> (3) NAAT/RNA <input type="checkbox"/> (4) Other test, specify: _____	<input type="checkbox"/> (1) Rapid <input type="checkbox"/> (2) Conventional <input type="checkbox"/> (3) NAAT/RNA <input type="checkbox"/> (4) Other test, specify: _____
Test result: <i>(mark one ☒)</i>	<input type="checkbox"/> (1) Positive <input type="checkbox"/> (2) Preliminary positive* <input type="checkbox"/> (3) Negative <input type="checkbox"/> (4) Indeterminate /Inconclusive <input type="checkbox"/> (5) Invalid <input type="checkbox"/> (6) No result <small>* Record confirmatory test result for preliminary positive rapid tests (HIV TEST #2).</small>	<input type="checkbox"/> (1) Positive <input type="checkbox"/> (2) Preliminary positive* <input type="checkbox"/> (3) Negative <input type="checkbox"/> (4) Indeterminate /Inconclusive <input type="checkbox"/> (5) Invalid <input type="checkbox"/> (6) No result <small>* Record confirmatory test result for preliminary positive rapid tests (HIV TEST #3).</small>	<input type="checkbox"/> (1) Positive <input type="checkbox"/> (2) Preliminary positive* <input type="checkbox"/> (3) Negative <input type="checkbox"/> (4) Indeterminate /Inconclusive <input type="checkbox"/> (5) Invalid <input type="checkbox"/> (6) No result <small>* Record confirmatory test result for preliminary positive rapid tests (HIV TEST #4).</small>
Results provided?	<input type="checkbox"/> (1) Yes <i>(record date provided)</i> Date result provided: <i>(mm/dd/yyyy)</i> <input type="text"/> <input type="checkbox"/> (1) Mark if client obtained result from another agency <input type="checkbox"/> (0) No <i>(indicate why)</i> If results not provided, why? <input type="checkbox"/> (1) Client declined notification <input type="checkbox"/> (2) Did not return / Could not locate <input type="checkbox"/> (3) Other	<input type="checkbox"/> (1) Yes <i>(record date provided)</i> Date result provided: <i>(mm/dd/yyyy)</i> <input type="text"/> <input type="checkbox"/> (1) Mark if client obtained result from another agency <input type="checkbox"/> (0) No <i>(indicate why)</i> If results not provided, why? <input type="checkbox"/> (1) Client declined notification <input type="checkbox"/> (2) Did not return / Could not locate <input type="checkbox"/> (3) Other	<input type="checkbox"/> (1) Yes <i>(record date provided)</i> Date result provided: <i>(mm/dd/yyyy)</i> <input type="text"/> <input type="checkbox"/> (1) Mark if client obtained result from another agency <input type="checkbox"/> (0) No <i>(indicate why)</i> If results not provided, why? <input type="checkbox"/> (1) Client declined notification <input type="checkbox"/> (2) Did not return / Could not locate <input type="checkbox"/> (3) Other

RISK FACTORS

Was client asked about HIV risk factors? (mark one)

(1) Risk factors discussed (2) Client was not asked about risk factors (3) Client declined to discuss risk factors

VAGINAL OR ANAL SEX (past 12 months)			ORAL SEX (past 12 months)	Number of alcoholic drinks on a typical day when drinking: (0 - 99)
MALE PARTNER	Had vaginal or anal sex with a male? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (9) Declined	Type of sex: (optional) (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Vaginal receptive <input type="checkbox"/> (1) Anal insertive <input type="checkbox"/> (1) Anal receptive	Had vaginal or anal sex with a male ... (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) without using a condom <input type="checkbox"/> (1) who injects drugs <input type="checkbox"/> (1) who is HIV positive <input type="checkbox"/> (1) known to have had sex with a male (if female)	Had oral sex with a male? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No
FEMALE PARTNER	Had vaginal or anal sex with a female? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (9) Declined	Type of sex: (optional) (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Vaginal insertive <input type="checkbox"/> (1) Anal insertive	Had vaginal or anal sex with a female ... (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) without using a condom <input type="checkbox"/> (1) who injects drugs <input type="checkbox"/> (1) who is HIV positive	Had oral sex with a female? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No
TRANSGENDER (TG) PARTNER	Had vaginal or anal sex with a TG? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (9) Declined	Type of sex: (optional) (mark all that apply <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Vaginal <input type="checkbox"/> (1) Anal insertive <input type="checkbox"/> (1) Anal receptive	Had vaginal or anal sex with a transgender person ... (mark all) <input type="checkbox"/> (1) without using a condom <input type="checkbox"/> (1) who injects drugs <input type="checkbox"/> (1) who is HIV positive	Had oral sex with a TG? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No

Used a needle to inject drugs? (past 12 months)
 (1) Yes → **If yes, shared needles or injection equipment?**
 (0) No (1) Yes
 (9) Declined (0) No

Other HIV behavior/exposure risk factors? (past 12 months, mark all that apply)
 (1) No additional risk factors
 (1) Diagnosed with syphilis, gonorrhea, or chlamydia
 (1) Stimulant drug use (speed, powder cocaine, crack)
 (1) Other behavior/exposure, specify:
Specify other behavior/exposure:

Total number of vaginal or anal sex partners: (past 12 months, 1 - 999)

Has received money, drugs, or other items or services for sex? (past 12 months) (1) Yes (0) No

Has had sex with a person who exchanges sex for drugs or money? (past 12 months) (1) Yes (0) No

PRELIMINARY & CONFIRMED POSITIVE RESULT

<p>Referred to HIV medical care? <input type="checkbox"/> (1) Yes → If yes, did client attend first appointment? <input type="checkbox"/> (1) Yes → Appointment date: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't know</p> <p><input type="checkbox"/> (0) No → If not referred to medical care, indicate why? <input type="checkbox"/> (1) Client already in HIV medical care <input type="checkbox"/> (2) Client declined HIV medical care</p> <p>Referred to HIV prevention services? <input type="checkbox"/> (1) Yes → If yes, did client receive HIV prevention services? <input type="checkbox"/> (0) No <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't know</p>	<p>If female, is client pregnant? <input type="checkbox"/> (1) Yes → If yes, in prenatal care? <input type="checkbox"/> (0) No <input type="checkbox"/> (1) Yes <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (0) No <input type="checkbox"/> (9) Declined <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (9) Declined</p> <p>Has the unique ID from this testing form been provided to your HIV/AIDS Surveillance Coordinator or program for inclusion on the HIV/AIDS Adult Case Report Form (ACRF)? <input type="checkbox"/> (1) Yes <input type="checkbox"/> (0) No</p>
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PARTNER SERVICES

<p>Were partner services discussed/offered this session? (mark one <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Offered and accepted <input type="checkbox"/> (2) Offered and refused <input type="checkbox"/> (3) Not offered</p> <p>Was skill building provided for self-notification? <input type="checkbox"/> (1) Yes → Number of partners to be self-notified: (0-999) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No</p>	<p>Was client interviewed for partner elicitation at this agency? (dual and 3rd party) <input type="checkbox"/> (1) Yes → Interview date: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No Number of partners: (0-999, dual & third party) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p> <p>Was partner services referred out to another agency? <input type="checkbox"/> (1) Yes → Specify agency: _____ <input type="checkbox"/> (0) No</p> <p>Was client interviewed for partner elicitation? <input type="checkbox"/> (1) Yes → Interview date: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No Number of partners: (0-999, dual & 3rd party) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (8) Don't know</p>
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HIV TESTING AND TREATMENT HISTORY

<p>Ever had a previous positive HIV test? <input type="checkbox"/> (1) Yes → Date of first positive HIV test: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (9) Declined</p> <p>Ever had a negative HIV test? <input type="checkbox"/> (1) Yes → Date of last negative HIV test: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (9) Declined <i>(if date is from a lab test with test type, enter in lab data section)</i></p> <p>Number of negative HIV tests within 24 months before first positive HIV test: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (9) Declined</p>	<p>Used or is currently using antiretroviral (ARV) medication? <input type="checkbox"/> (1) Yes (specify ARV used and indicate first and last date used) <input type="checkbox"/> (0) No <input type="checkbox"/> (8) Don't know <input type="checkbox"/> (9) Declined to answer</p> <p>Specify antiretroviral medications: _____ _____</p> <p>Date ARV first began: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p> <p>Date of last ARV use: (mm/dd/yyyy) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p>
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Data entry ID:

RACE / ETHNICITY CODES

Asian:	313 Laotian	Native Hawaiian/Pacific Islander:	Hispanic/Latino(a):
301 Asian Indian	324 Madagascar	422 Guamanian	505 Caribbean
302 Bangladeshi	314 Malaysian	411 Hawaiian	503 Central American
303 Bhutanese	321 Maldivian	403 Melanesian	507 Cuban
304 Burmese	322 Nepalese	402 Micronesian	502 Mexican
305 Cambodian	315 Okinawan	401 Polynesian	506 Puerto Rican
306 Chinese	316 Pakistani	412 Samoan	504 South American
308 Filipino	323 Singaporean	404 Other Pacific Islander	501 Spaniard
309 Hmong	317 Sri Lankan		599 Other Latino
310 Indonesian	307 Taiwanese		
320 Iwo Jiman	318 Thai		
311 Japanese	319 Vietnamese		
312 Korean	399 Other Asian		

CALIFORNIA COUNTY CODES

1 Alameda	13 Imperial	25 Modoc	37 San Diego	49 Sonoma
2 Alpine	14 Inyo	26 Mono	38 San Francisco	50 Stanislaus
3 Amador	15 Kern	27 Monterey	39 San Joaquin	51 Sutter
4 Butte	16 Kings	28 Napa	40 San Luis Obispo	52 Tehama
5 Calaveras	17 Lake	29 Nevada	41 San Mateo	53 Trinity
6 Colusa	18 Lassen	30 Orange	42 Santa Barbara	54 Tulare
7 Contra Costa	19 Los Angeles	31 Placer	43 Santa Clara	55 Tuolumne
8 Del Norte	20 Madera	32 Plumas	44 Santa Cruz	56 Ventura
9 El Dorado	21 Marin	33 Riverside	45 Shasta	57 Yolo
10 Fresno	22 Mariposa	34 Sacramento	46 Sierra	58 Yuba
11 Glenn	23 Mendocino	35 San Benito	47 Siskiyou	
12 Humboldt	24 Merced	36 San Bernardino	48 Solano	

STATE/TERRITORY CODES

AL Alabama	IL Illinois	MT Montana	RI Rhode Island	FM Federated States of Micronesia
AK Alaska	IN Indiana	NE Nebraska	SC South Carolina	GU Guam
AZ Arizona	IA Iowa	NV Nevada	SD South Dakota	MH Marshall Islands
AR Arkansas	KS Kansas	NH New Hampshire	TN Tennessee	MP Northern Mariana Islands
CA California	KY Kentucky	NJ New Jersey	TX Texas	PW Palau
CO Colorado	LA Louisiana	NM New Mexico	UT Utah	PR Puerto Rico
CT Connecticut	ME Maine	NY New York	VT Vermont	VI Virgin Islands of the U.S.
DE Delaware	MD Maryland	NC North Carolina	VA Virginia	88 Client does not currently reside in a US state, territory, or district.
DC District of Columbia	MA Massachusetts	ND North Dakota	WA Washington	
FL Florida	MI Michigan	OH Ohio	WV West Virginia	
GA Georgia	MN Minnesota	OK Oklahoma	WI Wisconsin	
HI Hawaii	MS Mississippi	OR Oregon	WY Wyoming	
ID Idaho	MO Missouri	PA Pennsylvania	AS American Samoa	

ANTIRETROVIRAL (ARV) MEDICATION CODES

22 Agenerase (amprenavir)	18 Invirase (saquinavir, SQV)	13 Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC,AZT)
30 Aptivus (tipranavir, TPV)	34 Intelence (etravirine)	27 Truvada (tenofovir DF/emtricitabine, TDF/FTC)
32 Atripla (efavirenz/emtricitabine/tenofovir DF)	36 Isentress (raltegravir)	01 Videx (didanosine, ddl)
24 Combivir (lamivudine/ zidovudine, 3TC/AZT)	16 Kaletra (lopinavir/ ritonavir)	14 Videx EC (didanosine, ddl)
06 Crixivan (indinavir, IDV)	31 Lexiva (fosamprenavir, 908)	17 Viracept (nelfinavir, NfV)
11 Emtriva (emtricitabine, FTC)	07 Norvir (ritonavir, RTV)	05 Viramune (nevirapine, NVP)
03 Eпивir (lamivudine, 3TC)	33 Prezista (darunavir, DRV)	12 Viread (tenofovir DF, TDF)
28 Epzicom (abacavir/lamivudine, ABC/3TC)	09 Rescriptor (delavirdine, DLV)	04 Zerit (stavudine, d4T)
25 Fortovase (saquinavir, SQV)	26 Retrovir (zidovudine, ZDV, AZT)	20 Ziagen (abacavir, ABC)
10 Fuzeon (enfuvirtide, T20)	15 Reyataz (atazanavir, ATV)	88 Other Antiretroviral
19 Hepsera (adefovir)	08 Saquinavir (Fortavase, Invirase)	99 Unspecified
02 Hivid (zalcitabine, ddC)	35 Selzentry (maraviroc)	
23 Hydroxyurea	21 Sustiva (efavirenz, EFV)	