



HIV Counseling/Testing Forms Instruction Guide

Directions for Completing the:

DH1628 Laboratory Request Form

DH1628c Post-Test Documentation Form

DH1818 Consent Form

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Overview of Changes on the DH1628 Laboratory Request Form

The DH1628 Form was revised in 2007:

- **To incorporate changes to CDC core variables related to PEMS**
- **To add information on hepatitis history so that clients testing for HIV and hepatitis during the same clinic visit only need to complete the DH1628**
- **To streamline and simplify the form**
- **To allow the form to be scanned**

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.

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.

LETTERS

Here are examples of how to write letters and numbers:

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

- ✓ In an effort to reduce paperwork when collecting risk information on HIV and hepatitis, the "hepatitis History" box was added to the 1628.
- ✓ Changes have been made in the risk factor section of the form based on CDC requirements and feedback from counselors.
- ✓ The testing history questions have been simplified, and several have been deleted.
- ✓ The "**PREVIOUS POSITIVE USE ONLY**" section has been moved to the lower part of the form and has been streamlined.
- ✓ The "**RAPID TEST USE ONLY**" section has been expanded to include additional variables, streamlining quality assurance data collection.

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

DH1628 Laboratory Request Form – Lab (Gold) Copy

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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 unscannable (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 and 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 barcode stickers instead of hand writing the site address and site number. Please contact your Early Intervention Consultant for more information on how to obtain barcode 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 - 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., 01/02/06) 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 **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.



***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.

- 8 **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.

Demographic Information

- 9** **On the first line, 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.
- 10** **On the second line, 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** **On the third line, please complete** the city, state and zip code of residence.
- 12** **On the fourth line, please write** the county and include any **additional locating information** (aliases, frequent hangouts, etc.) that might assist a DIS in locating this client if necessary (i.e., a client that may not have returned for results).
- 13** **On the fifth line, please write** the client's primary phone number and social security number.



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 information in this field.

- 14** **On the sixth line, please write** an additional phone number for the client (e.g., work, cell, relative, friend, pager, etc.), if available. Complete the Medicaid number if applicable.



****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: Please leave the space to the right of the Medicaid number blank as this space is used by the laboratory.



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 Hepatitis History** Ask the client if they have *ever* had hepatitis A, B or C and mark all appropriate bubbles. If they do not remember having hepatitis, leave the bubbles unmarked (NOTE: on the rare occurrence the client states an infection with some other form of hepatitis, write “other hep” in this box).

Ask if the client has *ever* tested positive for hepatitis A, B or C. Mark all appropriate bubbles (NOTE: positive tests may be either antibody or antigen tests). If their answer is “no” or they do not remember, leave the bubble blank.

Ask the client if they were *ever* vaccinated with hepatitis A or B vaccine and mark one or both bubbles as appropriate (NOTE: If they recall receiving Twinrix—which contains both the hepatitis A and B vaccine in a single dose—mark both bubbles).



NOTE: If an individual is only being tested for hepatitis (i.e., not being tested for HIV **AND** hepatitis), the Hepatitis 09 Program Risk Assessment form must be used.

- 20 Current Gender** Please mark only **one** box: either “**Male**”, “**Female**”, “**Transgender M to F**” or “**Transgender F to M**” for each client. This field represents how the client **self-identifies**.

- 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**”.



***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.

Risk Factors

23 Client risk data provide 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 ascertained 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.

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 HIV-positive person: The client has had vaginal or anal intercourse (protected or unprotected) with a person who is HIV positive.

Sex (vaginal or anal) with an IDU: The client has had had vaginal or anal intercourse (protected or unprotected) with a person who is an injecting drug user (IDU).

Sex (vaginal or anal) with a MSM: The client has had had vaginal or anal intercourse (protected or unprotected) with a person who has male-to-male sex.

Sex (vaginal or anal) without a condom: The client has had vaginal or anal intercourse without a condom

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.).

Risk Factors (continued)

23

continued

Hemophiliac/Blood recipient: The client has received a blood transfusion, blood products or any tissue or organ donation.

Sex for drugs/money/other items: The client had sex (anal, vaginal or oral) in exchange for drugs or money or something he/she needed.

Occupational exposure: The client has been exposed to HIV during the performance of their job duties (do not include sex worker).

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: The client was not able to identify any risk factors.

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 ascertain the reason a client wants to get tested.

Antiretroviral History

24 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.

“Last Day of ARV or HIV Medication” The date of the last day on which the client took antiretroviral medication. 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 form is being completed.

Testing History Questions

25 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** If they have been tested for HIV, please note the date of their **last** HIV test. Year of test must include all four digits, e.g., 2003.

✓**No** They have 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.

26 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 below.

✓**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.

Previous Positive Questions

27

This section applies only to clients who self-report as having had a positive HIV test result. Fill out this section for all clients who reported that the result of their last HIV test was positive in the preceding Testing History Section. Complete this section in its entirety for previous positive clients.

Date of FIRST positive test

Ask the client when was the first time they tested positive for HIV. Ask them the month and the year. The year must include all four digits, e.g., 2003.

This is not their most recent test result but rather the very first HIV positive test result they ever had. The year must include all four digits, e.g., 2003.

Write the month and the year on the blanks provided. The answer you write needs to include both the month and the year. If the client initially can only remember the year write that down and then work with them to come up with the month. Use probes that may help trigger their memory. Ask questions like “Was it cold outside?”, “Was it summer?”, “Was it around New Year’s Eve?”, etc.



If the client refuses to answer your question, write in “77” for the month and “7777” for the year.

If the client can not remember either the month or the year write in “99” for the month and “9999” for the year.

Previous Positive Questions (continued)

27

Date of your LAST negative test

continued

Ask the client for the date of their last **negative** HIV test. Ask for **BOTH** the **month** and the **year** and write that in the boxes provided. The year must include all four digits, e.g., 2003.

If the client's last HIV test was positive- write down the date of their last negative HIV test prior to testing positive.

If the client initially can only remember the year write that down and then work with them to come up with the month. Use probes that may help trigger their memory. As questions like "Was it hot out?", "Was it winter?", "Was it around Memorial Day weekend?", etc.

If the client refuses to answer your question, write in "77" for the month and "7777" for the year.

If the client can not remember either the month or the year write in "99" for the month and "9999" for the year.

If the client never tested negative, write in "88" for the month and "8888" for the year.

Number of HIV tests in the 2 years prior to your FIRST positive test

NOT INCLUDING TODAY'S TEST, ask how many times the client has been tested for HIV in the 2 years before their first positive test. Write that number in the blanks provided.



Please note: You need to write in **ONE** actual **number**; e.g., "12".

Do not write words such as "several", "often", etc. If the client says somewhere between 5 and 10, do not write "5-10". Work with the client to determine an actual number, then write in that number.

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

Rapid Test Use Only

28 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)

28

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.

Rapid Test Use Only (continued)

28

REFUSED CONFIRMATORY TEST

continued

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.



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

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

SITE ADDRESS

SITE NUMBER

LOCAL USE

LAB COPY
PLEASE SEE BACK FOR
INSTRUCTIONS



PERMANENT BARCODE

Counselor ID

PRE-TEST COUNSEL DATE

BLOOD
 ORAL
 DBS
 CD4/8
 V. LOAD
 GENOTYPE
 GENOTYPE PLUS

RAPID TEST
 REACTIVE

Last Name _____ First Name _____ M.I. _____
 Address _____
 City _____ State _____ Zip Code _____
 County _____ Additional Locating Information _____
 Phone 1 _____ Social Security # _____
 Phone 2 _____ Medicaid # _____

Date of Birth	Ethnicity (Select one)	Race (Select one or more)	hepatitis History
Country of Birth	<input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Don't Know <input type="radio"/> Refused	<input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> White <input type="radio"/> Don't Know <input type="radio"/> Refused	A B C Ever had? <input type="radio"/> <input type="radio"/> <input type="radio"/> Ever tested positive? <input type="radio"/> <input type="radio"/> <input type="radio"/> Ever vaccinated? <input type="radio"/> <input type="radio"/>

Current Gender	Pregnant	In Prenatal Care	Risk Factors																																																																		
<input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> Transgender/M to F <input type="radio"/> Transgender/F to M	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	<table border="1"> <thead> <tr> <th></th> <th>Past 12 months</th> <th>EVER</th> </tr> </thead> <tbody> <tr><td>Sex (vaginal or anal) with a male</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex (vaginal or anal) with a female</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex (vaginal or anal) with HIV-positive person</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex (vaginal or anal) with an IDU</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex (vaginal or anal) with a MSM</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex (vaginal or anal) without a condom</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Oral Sex</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Injection drug use</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td> If IDU, shared injection equipment</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Hemophiliac/Blood recipient</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Sex for drugs, money or other items</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Occupational exposure</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Victim of sexual assault</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>STD diagnosis</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Perinatal exposure to HIV</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Jail/Prison/Detention Center</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>No risk identified</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>Client refused to discuss risk (s)</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>In the past 12 months, how many different:</td><td></td><td></td></tr> <tr><td> Sex partners?</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td> Needle-sharing partners?</td><td><input type="radio"/></td><td><input type="radio"/></td></tr> </tbody> </table>		Past 12 months	EVER	Sex (vaginal or anal) with a male	<input type="radio"/>	<input type="radio"/>	Sex (vaginal or anal) with a female	<input type="radio"/>	<input type="radio"/>	Sex (vaginal or anal) with HIV-positive person	<input type="radio"/>	<input type="radio"/>	Sex (vaginal or anal) with an IDU	<input type="radio"/>	<input type="radio"/>	Sex (vaginal or anal) with a MSM	<input type="radio"/>	<input type="radio"/>	Sex (vaginal or anal) without a condom	<input type="radio"/>	<input type="radio"/>	Oral Sex	<input type="radio"/>	<input type="radio"/>	Injection drug use	<input type="radio"/>	<input type="radio"/>	If IDU, shared injection equipment	<input type="radio"/>	<input type="radio"/>	Hemophiliac/Blood recipient	<input type="radio"/>	<input type="radio"/>	Sex for drugs, money or other items	<input type="radio"/>	<input type="radio"/>	Occupational exposure	<input type="radio"/>	<input type="radio"/>	Victim of sexual assault	<input type="radio"/>	<input type="radio"/>	STD diagnosis	<input type="radio"/>	<input type="radio"/>	Perinatal exposure to HIV	<input type="radio"/>	<input type="radio"/>	Jail/Prison/Detention Center	<input type="radio"/>	<input type="radio"/>	No risk identified	<input type="radio"/>	<input type="radio"/>	Client refused to discuss risk (s)	<input type="radio"/>	<input type="radio"/>	In the past 12 months, how many different:			Sex partners?	<input type="radio"/>	<input type="radio"/>	Needle-sharing partners?	<input type="radio"/>	<input type="radio"/>
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Have you ever taken any Antiretroviral or HIV medicine? *See reverse for medicine codes and instructions*

Yes *which ones?* → _____ First day of ARV or HIV medication
 No
 Don't Know
 Refused

Last day of ARV or HIV medication _____

Previous HIV test?	Result of Last HIV Test
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused <i>If yes, date of last test</i>	<input type="radio"/> Positive <i>(complete section below)</i> <input type="radio"/> Negative <input type="radio"/> Reactive Rapid Test <input type="radio"/> Indeterminate <input type="radio"/> Don't Know <input type="radio"/> Refused

PREVIOUS POSITIVE USE ONLY *To be completed for clients who have previously tested positive*

Date of **FIRST** positive test _____ Date of your **LAST** negative test _____
 Number of HIV tests in the 2 years prior to your **FIRST** positive test _____
 In what STATE was your **FIRST** positive test performed _____
(Refused = 77/7777, Don't Know = 99/9999, Never tested negative = 88/8888)

RAPID TEST SITE USE ONLY

Test Type: Quick Urin-Gold Other _____
 Was Client Given Rapid Test Result? YES NO

What was the Result? **Reactive** Mark **RAPID TEST REACTIVE** box at top of form
 Non-Reactive If NR, mail form to Tallahassee, see reverse for instructions
 REFUSED CONFIRMATORY TEST

Test Kit Lot Number _____ Test Kit Expiration Date _____
 Type of Sample Tested Finger Stick Venous Blood Draw Oral Fluid _____
 Time Test Begin _____ Time Test Read _____

DH Form 1628, 05/07, (Obsolete 11/05 edition may not be used) (Stock number 5740-000-1628-3)

Return Appointment (29)

State of Florida Department of Health
Bureau of Laboratory Services

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

Tear off and give reminder card to client with return appointment
PLACE SCAN STICKER HERE
 Return Appointment Date _____ / _____ / _____
 Return Appointment Location _____
 Agency Phone Number _____
30

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

29 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.

30 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.

Scan ID #

HIV POST-TEST DOCUMENTATION FORM

Lab ID #

Additional risk exposures identified during post-test:

2

MAIL WITHIN ONE MONTH OF POST TEST TO:

Attn: Counseling and Testing Data
Department of Health
Bureau of HIV/AIDS
4052 Bald Cypress Way, BIN A09
Tallahassee, FL 32399-1715

3

POST-TEST DATE:

Month	Day	Year
JAN	0	0 2007
FEB	1	1 2008
MAR	2	2 2009
APR	3	3
MAY	4	4
JUN	5	5
JUL	6	6
AUG	7	7
SEP	8	8
OCT	9	9
NOV		
DEC		

1

COUNSELOR ID

4

Negative test, retest in: _____ / _____
Month Year

HIV-POSITIVE CLIENTS ONLY LINKED TO:

	Yes	No	
HIV Prevention Services	<input type="radio"/>	<input type="radio"/>	5
Partner Services	<input type="radio"/>	<input type="radio"/>	
Medical Care	<input type="radio"/>	<input checked="" type="radio"/>	If no, why? <input type="radio"/> Client already in care <input type="radio"/> Client declined care
Client attended FIRST medical appointment	<input type="radio"/>	<input type="radio"/>	Yes No Unknown
Prenatal Care	<input type="radio"/>	<input type="radio"/>	Yes No Unknown
Client attended FIRST prenatal appointment	<input type="radio"/>	<input type="radio"/>	Yes No Unknown


Mail-To Facility Name SITE NUMBER
Street address
City State Zip
Attention:


Original Testing Site
Submitting Facility Name SITE NUMBER
Street address
City State Zip


SEE INSTRUCTIONS ON BACK:

This copy should be mailed to the Bureau of HIV/AIDS within one month of post-test counseling.

Instructions for Completing the DH1628c HIV Post-Test Documentation Form

- 1 Indicate date of post-test counseling session by carefully marking the bubbles corresponding to the month, day and year of post-test. You may partially or completely fill in the bubble or put an "X" in the center. 
- 2 All clients should have their risk information updated during post-test counseling. Please note additional risks disclosed on the lines provided.
- 3 Mail the completed form within one month of post-test counseling to the address listed on the left side of the form. Do not place client identifying labels on the DH1628c. You MAY place the corresponding scan id sticker under the lines for risk information. If you put any client identifying information on this form, you must send the form to Tallahassee via traceable mail.
- 4 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. You may also include the counselor initials or number in the spaces provided.
- 5 For HIV-infected clients only, indicate whether the client was linked to HIV prevention services, partner services (formerly PCRS), HIV medical or prenatal care. For HIV-infected clients accepting the referral to medical or prenatal care, indicate whether or not they attended the first appointment. If the client does not accept linkage to HIV medical care, indicate the reason.

 ALL HIV-INFECTED CLIENTS SHOULD BE REFERRED TO 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.

 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 and
- 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	<i>Client must indicate if they wish to be tested by checking "Yes" or "No"</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO		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.
Check Here		I consent to be tested.
	2	
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	<i>Client must initial the consent statement and then sign below. The consent form must be dated and witnessed.</i>	
REQUIRED	1	
YES _____ 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	4
_____	_____	_____
Date	Signature of Client or Legal Representative	Client's Printed Name
5	6	
_____	_____	
Witness Signature	Legal Representative's Relationship to the Client (If Applicable)	

OPTIONAL	7	
YES _____ 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.
- DH1818, 05/05. (Obsoletes 03/04edition which may not be used) Stock Number: 5740-000-1818-9

Instructions for Completing the DH1818 Consent Form (Confidential)

- ① The client should place their initials on either the “Yes” or the “No” line to indicate s/he has been informed about and consents to 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. If “Yes” is chosen, please complete the information requested (the name and address of their preferred physician).
- ⑧