HIV COUNSELING AND TESTING REPORT FORM

NC Department of Health and Human Services
State Laboratory of Public Health
306 N. Wilmington Street PO Box 28047
Raleigh, NC 27611-8047

[2] **Label**

[1]

Bar Code

[3] Patient Information

Last Name

First Name **MI**

County **State** **Zip Code**

Is patient on Medicaid? ☐ Yes ☐ No **Medicaid ID**

Other Patient ID- Local Use

SSN ___ - __ - ____ **DOB** MM / DD / CCYY

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Race - (mark all that apply) ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Isles ☐ Unknown

Current Gender ☐ Male ☐ Female ☐ Unknown ☐ Transgender **Birth Sex** ☐ Male ☐ Female ☐ Unknown

[4] Visit Information

Site Number **EIN Number** **Date of Visit** MM / DD / CCYY

Site Type ☐ HIV CTS ☐ Drug Treatment ☐ TB Clinic ☐ Community Health ☐ Field Visit ☐ Outreach ☐ STD Clinic ☐ Family Planning ☐ Prenatal/OB ☐ Prison/Jail ☐ Hospital/Private MD ☐ Other

[5] Testing Information

[5.1]

Patient PreviouslyTested/ Result?

☐ No previous test
☐ Yes, negative
☐ Yes, positive
☐ Yes, indeterminate
☐ Yes, result unknown

Most recent test date known? ☐ Yes ☐ No

If Yes,

Most Recent Test Date MM / CCYY

[5.2] Lab Testing

A. Patient tested this visit & Sample Sent to Lab? ☐ Yes ☐ No

If No, go to C.

B.Type of Sample

☐ Serum ☐ Blood Spot
☐ Plasma ☐ Oral Mucosal Transudate
☐ Whole Blood ☐ Urine
☐ Cadaveric Fluid

C.If Not Tested This Visit, Indicate Reason

☐ Client Declined ☐ Previously Negative
☐ Referred Elsewhere ☐ Other
☐ Previously Positive

[5.3] Preliminary Testing

Preliminary Rapid Test Perfomed? ☐ Yes ☐ No

Rapid Test Used ☐ OraQuick ☐ Reveal ☐ Uni-Gold ☐ Other

Lot Number

Rapid Test Brand - (If Other)

Type of Specimen ☐ Oral ☐ Blood

Rapid Test Result This Visit ☐ Negative ☐ Indeterminate ☐ Positive ☐ Unsatisfactory

Rapid Test Results Provided to Client? ☐ No ☐ Yes, at new client visit ☐ Yes, same day ☐ Yes, Other ☐ Yes, follow-up for this visit

[6] Lab Use Only

Do Not Remove Bar Code

[7] Specimen Missing ☐

Specimen Received ☐

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[8] Pre-Test Counseling Information

Pretest Counselor

Client Counseled
☐ Yes ☐ No

STARHS Consent
☐ Yes ☐ No

If Female, Is Patient Pregnant?
☐ Yes ☐ No ☐ Unknown

If Pregnant, In Prenatal Care
☐ Yes ☐ Refused to Answer
☐ No ☐ Not Asked

Outreach Venue?
☐ Yes ☐ No

Reason for the Visit - (mark all that apply)

- ☐ Symptomatic for HIV/AIDS
- ☐ TB Related
- ☐ Client Referral
- ☐ Court Ordered
- ☐ Provider Referral
- ☐ Immigrant/Travel Req
- ☐ STD Related
- ☐ Occupational Exposure
- ☐ Drug Trmt Related
- ☐ Retest
- ☐ Family PL Related
- ☐ Requesting HIV Test
- ☐ PreNatal/OB Related
- ☐ Other

Risk Behaviors within the last 12 months - (mark all that apply)

- ☐ Sex with man
- ☐ Child of HIV infected woman
- ☐ Sex with woman
- ☐ Sex while using non-inj drugs
- ☐ Injection Drug Use
- ☐ Sex with other HIV/Aids Risk
- ☐ Sex with HIV+ person
- ☐ Hemophilia/Blood Recipient
- ☐ Sex with IDU
- ☐ Health Care Exposure
- ☐ Sex with MSM
- ☐ Victim of Sexual Assault
- ☐ Sex in exchange for drugs/money
- ☐ No acknowledged Risk
- ☐ Current STD diagnosis
- ☐ Other Risk

[9] Additional Demographic Information

Primary Language
☐ English ☐ Spanish ☐ Other

Other Primary Language

[10] Local Use Data Fields

Local Use Field 1

Local Use Field 2

Local Use Field 3

Local Use Field 4

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. Follow the sample letters and numbers as closely as possible.

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

1	2	3	4	5	6	7	8	9	0

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