# 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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