



# HIV Counseling/Testing Forms Instruction Guide

Directions for Completing the:

DH1628 Laboratory Request Form

DH1628c Post-Test Documentation Form

DH1818 Consent Form

(This Forms Instruction Guide was last revised 05/2016)



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# Overview of Changes on the DH1628 Laboratory Request Form

The DH1628 Form was revised in 2016 to:

- >Update the “mail to” address on the back of the form
- Include information regarding testing for or use of Pre-exposure prophylaxis (PrEP) or negative, post-exposure prophylaxis (nPEP)
- >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.

## **DH1628**

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.

Please follow the below examples of writing information into the DH1628 form:

### LETTERS

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

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



0501800000  
CD

SITE ADDRESS

SITE NUMBER

LOCAL USE

LAB COPY  
PLEASE SEE BACK FOR  
INSTRUCTION

7

(f8) ☒ BLOOD ☐ ORAL ☐ DBS ☐ CO4a ☐ V. LOADQ RAPID TEST  
REACTIVELast  
Name

9

First Name

Q

Address

DD

City

11

State

Zip Code

County

12

Additional  
Locating  
Information

Phone 1

13

14 Last 4 of Social Security #

Phone 2

Medicaid #

unmnu

Date of Birth

15

Ethnicity (Select one)

- ☐ Hispanic or Latino  
☐ Not Hispanic or Latino  
☐ Don't Know  
☐ Refused

Race (Select one or more)

- ☐ American Indian/  
Alaskan Native  
☐ Asian  
☐ Black/African  
American  
☐ Native Hawaiian/  
Pacific Islander  
☐ White  
☐ Don't Know  
☐ Refused

Self-Reported Gender

- ☐ Male  
☐ Female  
☐ Transgender/M to F  
☐ Transgender/F to M  
☐ Transgender/Unspecified

Birth Sex

- ☐ Male  
☐ Female  
☐ Refused

Pregnant

- ☐ Yes  
☐ No  
☐ Don't Know  
☐ Refused

In Prenatal Care

- ☐ Yes  
☐ No  
☐ Don't Know  
☐ Refused

## Testing History Questions

Previous HIV Test?

- ☐ Yes  
☐ No  
☐ Don't Know  
☐ Refused

Result of Last HIV Test

- ☐ Positive  
☐ Negative  
☐ Reactive Rapid Test  
☐ Indeterminate  
☐ Don't Know  
☐ Refused

## Risk Factors

Past 12 months

Ever

Male Female Transgender Male Female Transgender

Vaginal or Anal Sex with

Without using a condom

With an IDU

With an HIV + person

Have you ever taken any Antiretroviral or HIV medicine?

Yes, PrEP

First day of PrEP

Last day of PrEP

/ /

/ /

Yes, nPEP

First day of nPEP

Last day of nPEP

/ /

/ /

Yes, HIV Positive

First day of HIV medication

Last day of HIV medication

/ /

/ /

Yes, to trust Htpitn No Don't Know Refused

Has the client:

Past  
12 months

Ever

... had vaginal/anal sex with an MSM? (FEMALE only)

... had an anonymous partner?

... had sex for drugs, money or other items?

... had an STD diagnosis?

... used injection drugs?

If YES, did they share injection equipment?

No risk identified

Refused to discuss risk factors

In the past 12 months, how many different:

Sex partners?

Needle-sharing partners?

## RAPID TEST SITE USE ONLY

OoraQuick

Alclearview

Determine

Q Insti

Other

Q Reactive

MarX RAPID TEST REACTIVE box at  
top of form

Q Non-Reactive

If NR, mail form to Tallahassee,  
see reverse for instructionsQ Non-Reactive: possible acute  
Send BLOOD specimen to Lab

Test Kit Lot Number

Test Kit Expiration Date

Q Finger Stick

Q Venous Blood Draw

Q Oral Fluid

Total test processing time: MINUTES

Result Given?

YES NO

REFUSED CONFIRMATORY TEST

n/m/ECB

# 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

- O) 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 not able to be scanned (accidentally gets torn, etc.).

County health department (CHD) sites ordering HIV tests through HMS will print an HMS sticker and place it over the printed barcode. An HMS sticker will also be placed on the specimen that is sent to the lab. **Do not** place HMS stickers over the barcode for **nonreactive rapid tests**. Sites should print as many stickers as needed for the form, specimen, return appointment card and rapid test requirements.

- CD 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.

- CD 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. 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 client demographic stickers instead of hand writing the site address and site number. Please contact your EIC for more information on how to obtain the 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 - CHD 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)

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-  **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 are determined at the local level.
-  **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 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.
-  **Pre-Test Counsel Date** Completely and legibly fill in the month, day and year (e.g., 01/02/11) 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.
-  **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.
-  **Blood, Oral, Dried Blood Spot (DBS), CD4/8, Viral Load, Rapid Test Reactive** 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.



**NOTE:** If the form is being used by a qualified medical provider to order a CD4/8 and/or viral load 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.

# Demographic information

- 9** **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.



**NOTE:** When using a pre-printed label, make sure and place the label on both the yellow and green copies of the DH1628.

- 10** **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** **Please complete** the city, state and zip code of residence.

- 12** **Please write** the county and include any **additional locating information** (aliases, frequent hangouts, etc.) that might assist a Disease Intervention Specialist (DIS) in locating this client if necessary (i.e., a client that may not have returned for results).

- 13** **Please write** the client's primary and secondary phone number.

- 14** **Please write** the client's Medicaid number (if applicable) and the last four digits of the client's Social Security Number (SSN).



**NOTE:** 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 other information in this field.



**\*\*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:** 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.

**©** **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**".

**©** **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)

- © **Self-Reported Gender** Please mark only **one** box: either "**Male**", "**Female**", "**Transgender/M to F**", "**Transgender/F to M**" or "**Transgender/Unspecified**" for each client. This field represents how the client **self-identifies**.
- © **Birth Sex** The biological sex assigned to the client at birth, (i.e., the sex noted on the client's birth certificate). *Instructions:* Indicate whether the client reports being physically born a male or female (i.e., being born with male or female genitalia), or "**Refused**" to answer.
- @ **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**".
- 9 **NOTE:** Please note that this field is particularly important because STD investigators will prioritize HIV-infected pregnant women.
- @ **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.

# Testing History Questions

*Complete these sections in their entirety for all clients. When asking clients about dates of previous tests, please encourage them to think back to the most exact date. If they cannot not recall exact dates ensure you collect exact four digit year.*



**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** The client has been tested for HIV before today.
- ✓**No** The client has 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.



**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.
- ✓**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.

# Testing History Questions (continued)

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Ask the client if they are testing today to get a baseline test to begin PrEP or nPEP. PrEP is a pill taken daily to prevent HIV infection when used in combination with other risk reduction strategies. Clients beginning PrEP must take an HIV test before beginning to be sure they don't already have HIV and every 3 months while they are taking it.

nPEP is a combination of pills taken daily for 28 days to prevent HIV infection after a high-risk exposure to HIV. Because persons who are infected with HIV might not be aware they are infected, baseline HIV testing should be performed on all persons seeking evaluation for potential nonoccupational HIV exposure. If possible, this should be done with an FDA-approved rapid test kit.



# Antiretroviral History



**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 taking antivirals for PrEP, nPEP and persons that are being treated for hepatitis.

**9**

**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 is taking antiretroviral medication for **PrEP** mark "Yes, PrEP" Write the date of the **first day** on which the client took **PrEP**. Ask for the two digit month, the two digit day, and the four digit year. If the client does not know the exact date leave blank. For example, if the client reports month and year, record 05/\_\_\_/ 2016. Do not record '99' for unknown information.

Ask for the two digit month, the two digit day, and the four digit year of the **last day** that the client took **PrEP**. If the client does not know the exact date, leave blank. For example, if the client reports month and year, record 05/\_\_\_/ 2016. Do not record '99' for unknown information. If the client is currently taking **PrEP**, then the last day of **PrEP** should be the date that the interview is being completed.

- ✓ If the client is taking antiretroviral medication for **nPEP** mark "Yes, nPEP." Write the date of the **first day** on which the client took **nPEP**. Ask for the two digit month, the two digit day, and the four digit year. If the client does not know the exact date leave blank. For example, if the client reports month and year, record 05/\_\_\_/ 2016. Do not record '99' for unknown information.

Ask for the two digit month, the two digit day, and the four digit year of the **last day** that the client took **nPEP**. If the client does not know the exact date, leave blank. For example, if the client reports month and year, record 05/\_\_\_/ 2016. Do not record '99' for unknown information. If the client is currently taking **nPEP**, then the last day of **nPEP** should be the date that the interview is being completed.

# Antiretroviral History - Continued



If the client is **HIV positive** and is taking antiretroviral medication mark “Yes, HIV Positive.” Write the date of the **first day** on which the client took HIV medication. Ask for the two digit month, the two digit day, and the four digit year. If the client does not know the exact date leave blank. For example, if the client reports month and year, record 05/\_\_\_/2016. Do not record '99' for unknown information.

Ask for the two digit month, the two digit day, and the four digit year of the **last day** that the client took HIV medication. If the client does not know the exact date, leave blank. For example, if the client reports month and year, record 05/\_\_\_/2016. Do not record '99' for unknown information. If the client is currently taking HIV medication, then the last day of HIV medication should be the date that the interview is being completed.

If the client is taking antiretrovirals to treat hepatitis, mark “Yes, to treat Hepatitis”

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”.

# Risk Factors

- 27** Client risk data provides 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 had an anonymous partner). 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 captured 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 within the last 12 months that would place him or her at risk of either being exposed to HIV or transmitting HIV. The sexual risk factors in this section ("Sex with male", "Sex with female" and "Sex with transgender") apply only to vaginal and anal sex.

**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 transgender:** The client has had vaginal or anal intercourse (protected or unprotected) with a person known to him or her to be a transgender.



**NOTE:** Respond to the following only if the client reported vaginal or anal sex with male, female or transgender. If the client did not report having vaginal or anal sex with a male, female or transgender, then do not select any additional client risk factors. If the client knows he or she has an additional client risk factor (e.g., sex "with a person who is an IDU") but he or she does not remember the sex of the person (in this case the IDU), the provider should ask the client for his or her best guess as to whether the partner(s) were male, female or transgender.

**Without using a condom:** The client has had sex without using a condom.

**With an IDU\*:** The client has had sex with a person who he or she knows to be an IDU.

**With an HIV-positive person:** The client has had sex with a person who he or she knows was HIV positive.

\*IDU is a common abbreviation for injection drug user

# Risk Factors (continued)



continued

For the following risk factors, it is not necessary to determine the partner's gender. Just identify if the client has engaged in any of these behaviors in the times specified.

➤ **With an MSM:** The client is female and has had sex with a person who she knows has male-to-male sex.

➤ **With an anonymous partner:** The client has had sex with a person whose identity was unknown to the client. A person's identity is a set of behavioral or personal characteristics by which that person is known. This can include information about a person's name, address, and habits that allow the client to identify the person.

➤ **For drugs/money/other items:** The client participated in sex events in exchange for drugs or money or something they needed.

➤ **STD diagnosis:** The client has been diagnosed with an STD other than HIV.

➤ **Injection drug use:** The client has used illicit injection drugs/substances (including narcotics, hormones, silicon, etc.).

➤ If the client is an injection drug user (IDU), ask if they have shared injection equipment (includes needles, syringes, cookers, cotton, etc.).

➤ **No risk identified:** No risk identified is selected when the client was asked about risk factors, but reports none of the risk factors listed.

➤ **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 understand the reason a client wants to get tested.



# 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.

If the test kit you are using states the month, day and year of expiration, please only write the month and year.

**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 a tube of blood drawn from the client's vein, mark "Venous Blood Draw".

✓ If the specimen is collected from the client's mouth, mark "Oral Fluid".

**Total Processing Time**

Record the amount of time the test was allowed to process (i.e., the amount of time from when the device was inserted into the developer solution vial or after the buffer solution was added to the time the test result was read).

**NOTE:** The total processing time must be in accordance with the manufacturer's instructions.

# Rapid Test Use Only (continued)



## Was Client Given Rapid Test Result?

ΔIf the client was given the result of their rapid test, mark "**Yes**".

ΔIf 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.

**REFUSED CONFIRMATORY TEST** 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.



## What was the Result?

ΔIf the client has a reactive rapid test, mark "**Reactive**".

ΔIf the client has a negative rapid test, mark "**Non-Reactive**".

ΔIf the client has a negative rapid test but has indicated that they have had a recent exposure to HIV, counselors should encourage additional testing. If a blood is drawn for further testing by the state lab, mark "**Non-Reactive: possible acute**". DO NOT mark the "Rapid Test Reactive" box at the top of the form.



**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 HIV/AIDS Section.



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

HIV/AIDS Section  
4025 Esplanade Way  
Tallahassee, FL 32399  
Attention: Rapid Testing Data/Room 304



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

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## 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.

§

## 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. CHD sites ordering HIV tests through HMS will print an HMS sticker and place it 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 HIV/AIDS Section.



bean ID #

1

post-RES DATE:

Month

Day

Year

2

COUNSELOR ID

Lab ID #

3

Negative test retest in:

Month / Year

PREGNANT:

Risks:

late collected:

worker #:

late received:

local use:

late reported:

laboratory Interpretation:

IA:

WB:

Suppl. IA:

NAAT:

CD4 Count:

CD8 Count:

CD4/8 Ratio:

Viral Load:

Comments

or if wvy kwmp Site

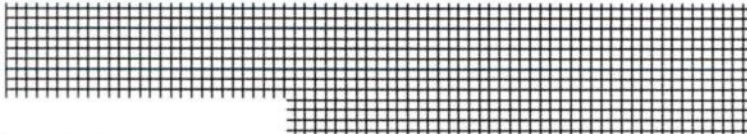
EST SITE COPY

CONFIDENTIAL

im 1678c (01/12) [Replaces DH FOTIW 1628c (11/09)]

Scan ID #

Lab ID #



Negative test retest in:

Month / Year

late collected:

worker #:

late received:

local use:

late reported:

laboratory Interpretation:

IA:

WB:

Suppl. IA:

NAAT: :

CD4 Count:

CD8 Count:

CD4/8 Ratio:

Viral Load:


Comments


QjqrwJ frsUig SHe


CLIENT COPY


# Instructions for Completing the DH1628c HIV Post-Test Documentation Form

It is required that all clients be offered post-test counseling. The *Test Site* copy of the DH1628c must be retained by the test site and the client should be given the *Client* copy of the DH1628c. The *Test Site* copy of the DH1628c must be available for Quality Assurance audits by the Department.

 **Post-Test Date** On the *Test Site* page of the DH1628c, indicate date of post-test counseling session by entering the date in the corresponding boxes for the two-digit month, two-digit day and two-digit year of post-test session (e.g., 11/28/09).

 **Counselor ID** You may also include the counselor initials or number in the spaces provided. Your Counselor ID is assigned to you by the agency you are employed by or are volunteering with.

 **Retest date** 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.

 **NOTE:** ALL HIV-INFECTED CLIENTS SHOULD BE LINKED TO CASE MANAGEMENT, MEDICAL CARE AND 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.



**NOTE:** 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
- 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** *Client must indicate if they wish to be tested by checking "Yes" or "No"*

\_\_\_\_ YES \_\_\_\_ NO

Check 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.

I consent to be tested.

**2**

Date \_\_\_\_\_

**3**  
Place DH1628 Scan ID sticker here

**4**

Witness Signature \_\_\_\_\_

**5**

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 03A14, 07/87 editions which may not be used) Stock Number: 5740-000-1818-9

## Instructions for Completing the DH1818 Consent Form (Anonymous)



The client should indicate if they wish to take the HIV test by checking either "Yes" or "No".



The client should write the date (month, day and year) on the line provided.



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.



The counselor should sign their name, as a witness, on the line provided.



The counselor should write the date (month, day and year) on the line provided.





**State of Florida Department of Health**  
**CONSENT FORM**  
**CONFIDENTIAL HUMAN IMMUNODEFICIENCY VIRUS (HIV) 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 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.

<p><b>CONSENT GIVEN</b></p> <p><b>REQUIRED</b></p> <p style="text-align: center;"><b>1</b></p> <p><b>YES</b> <b>NO</b></p> <p><b>Initial Here</b></p>	<p><i>Client must initial the consent statement and then sign below. The consent form must be dated and witnessed.</i></p> <p>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.</p>		
<p style="text-align: center;"><b>2</b></p> <p><b>Date</b></p>	<p style="text-align: center;"><b>3</b></p> <p><b>Signature of Client or Legal Representative</b></p>	<p style="text-align: center;"><b>C</b></p> <p><b>Client's Printed Name</b></p>	
<p style="text-align: center;"><b>C</b></p> <p><b>Witness Sig</b></p>	<p style="text-align: center;"><b>C</b></p> <p><b>Legal Representative's Relationship to the Client (If Applicable)</b></p>		

<p><b>OPTIONAL</b></p> <p style="text-align: center;"><b>7</b></p> <p><b>YES</b> <b>NO</b></p> <p><b>Initial Here</b></p> <p><b>If Applicable</b></p>	<p>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.</p>		
<p style="text-align: center;"><b>8</b></p> <p><b>Preferred Physician or Facility and their Mailing Address</b></p>			

**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 the 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.

OMicic: CV05 [Obao 3304401 or wlmf may not be used] Stock Number: 5740000-1018-0

# Instructions for Completing the DH1818 Consent Form (Confidential)

- CD** The client should place their initials on the “Yes” line to indicate they have been informed about and consent to HIV testing. The client should place their initials on the “No” line to indicate they have been informed about and decline HIV testing.
- 2** The client should write the date (month, day and year) on the line provided.
- D3D** 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.
- (R)** 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.
- 8** If “Yes” is chosen, please complete the information requested (the name and address of their preferred physician).