CAROLINA FAMILY HEALTH CENTERS, INC.

HIV Outreach and Testing Form

Client Demographic Information **Location of Event:** _____

Last Name _____ **First Name** _____ **MI** ____ **DOB** MM ____/ DD ___/ YYYY _____

Address _____ **County** _____ **State**_____ **Zip Code** _____

Ethnicity
☐ Hispanic ☐ Non-Hispanic

Race
☐ White ☐ Black ☐Asian ☐ American India ☐ Unknown

Gender
☐ Male ☐Female ☐Transgender

Sex at Birth
☐ Male ☐ Female

Date of Visit
____/____/____

Testing Site
☐ WCHC ☐HFHC ☐FHCHC ☐Outreach ☐Migrant Outreach
☐ Church ☐Prison/Jail ☐ School ☐ Homeless Shelter ☐Other

Pre-Test Counseling Information

Pretest Counselor's name (printed)
_____

Client Counseled
☐ Yes ☐ No

Pregnant
☐ Yes ☐ No ☐Unknown

Previous Testing

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

Rapid Testing **Type of Specimen** **Rapid Test Result This Visit**

Rapid Test Used
☐ Clearview ☐ Uni-Gold ☐ Other:____

Lot Number_____

Rapid Test Brand _____

☐ Oral ☐ Blood

☐ Negative ☐ Positive
☐Indeterminate ☐Unsatisfactory

Rapid Test Result Provided to Client?
☐ No ☐ Yes

Date rapid results provided to client
MM DD YYYY _____/_____/_____

Consent to Test for HIV-Confidential ***(client to initial)***

___ I have been informed that I will receive my initial HIV test results today. I understand that a negative test result is final and does not require confirmation.

___ I have been informed that a reactive rapid HIV test result must be confirmed by laboratory based test. It is my responsibility to follow-up with my doctor if my results are positive.

___ I was given a copy of Carolina Family Health Center's Notice of Privacy Practice

_____ _____
Client's Signature *Date*

Confirmatory Testing

Date of Confirmatory Testing
MM/DD/YYYY ____/____/____

CFHC, Inc. Lab
☐ Yes ☐ No

If not CFHC lab, Laboratory Used for Confirmatory Test
_____

Date of Confirmatory Test Results Received
MM/DD/YYYY ____/_____/_____

If not tested, why?
☐Client Declined ☐Other _____

Positive Tests: Patient Referrals

For Confirmed Positive Test

Date Client referred to Partner Counseling and Referral Services (PCRS)
MM/DD/YYYY _____/_____/_____

Date Client referred for Care Services
MM/DD/YYYY _____/_____/_____