Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

HIV Outreach and Testing Form

Patient Demographic Information **Date:**

Last Name _____ First **Name** _____ **MI** _____

DOB _____/____ /_____

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

Ethnicity
☐ Hispanic (Mexican/Mexican American/Chicano(a), Puerto Rican, Cuban or Other (circle one))
☐ Non-Hispanic

Race
☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Pacific Islander (Native Hawaiian, Guamanian/Chamorro, or Samoan (circle One))
☐ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or Other Asian (Circle One))
☐More than one race
☐Chose not to disclose

Gender Identity
☐ Male ☐Female ☐Transgender

Sex at Birth
☐ Male ☐ Female

Sexual Orientation
☐ Heterosexual ☐ Homosexual (lesbian or gay) ☐ Bisexual ☐Other ☐ Chose not to Disclose

Testing Location/Event:

Patient Consent for HIV Screening:

I have been given a copy of Carolina Family Health Center's Notice of Privacy Practice. I consent to being screened for HIV today. I have been provided information about HIV and other sexually transmitted diseases, modes of transmission, and way to prevent the spread of infection. I understand that a negative test result is final and does not require confirmation. A positive test result will need to be verified with additional testing. It is my responsibility to follow up with my primary care provider (PCP) for confirmatory testing, if needed. If I do not have a PCP, the outreach staff will make a referral for further testing at one of Carolina Family Health Center, Inc.'s locations.

_____ _____
Patient's Signature Date

Patient's Name _____ DOB: _____

Unique Identifier Number: _____

HIV Testing Information

Rapid Test Used

☐ OraSure ☐ Chembio ☐ Other: _____ Specimen: ☐ Oral ☐ Blood

Lot Number_____ Expiration Date _____
☐Indeterminate ☐Unsatisfactory

Results:
☐ Negative ☐ Positive ☐Indeterminant

Rapid Test Result Provided to Client?
☐ No ☐ Yes

If positive, where will confirmatory testing be conducted? _____

Date of Appointment: _____

Employee Name (printed): _____

Employee Signature: _____ Date: _____

Confirmatory Testing

Date of Confirmatory Testing: _____

Results:
☐ Negative ☐ Positive ☐Indeterminant

Ordering Provider: _____

Employee Name (printed): _____

Employee Signature: _____ Date: _____