INSTRUCTIONS FOR COMPLETING THE
HIV-ab SEROLOGY LAB FORM 2.0
RAPID TEST PROVIDERS ONLY
(ADPH-CL-109) **Revised 10/2012**

The form **must** be completed as instructed to assure accurate information is collected. When completing the form by hand, please print legibly. Check the square or circle to indicate responses. Use a ball point pen to complete the form, please press firmly to ensure that the all marks come through on all copies of the form.

Please note the following:
The HIV-ab Serology Lab Form 2.0 (ADPH-CL-109) is to be completed on each individual who, following pretest counseling and signed consent is tested for HIV-ab. All clients must have provided consent as documented by your agency policy for HIV testing. All clients have the right to "opt out" of HIV testing.

PATIENT INFORMATION

If completing **Patient/Provider** information by hand, complete as follows: (numbers on form correspond to numbered instructions)

1. Patient's Last Name
2. Patient's First Name
3. Patient's middle initial
4. Date of Birth (Month,day, year – xx/xx/xxxx)
5. CHR # Skip
6. Patient's Birth Sex
7. Patient's Current Gender
8. Patient's **9 digit** Social Security Number (If the person does not have a SS# leave the field blank.)
9. Date Specimen Collected (month, day, year)
10. Ethnicity (Choose only one.)
11. Race (Check all that apply.)
12. Patient's Address
13. Patient's County Code (Pg. 3)
14. Patient's Apartment Number
15. Patient's City
16. Patient's State
17. Patient's Zip Code
18. Patient's Telephone Number
19. Provider Name
20. Provider Site Code (Pg. 3)
21. Provider County (Pg. 3)
22. Provider Zip Code
23. Provider Address*

24. Provider City (No abbreviations.)
* A provider may use a stamped address on all four copies of the form. The Site Code and County Code will need to be completed in addition to the stamped address.

Test Technology

25. Check the square that corresponds to the test technology. **(ex. rapid)**
26. Check the square that corresponds to the specimen type. **(ex. oral mucosal transudate)**
27. Date Received (Lab Only) Skip
28. Date Reported (Lab Only) Skip
29. Check the appropriate (EIA) test result. **(Please remember to enter a test result. Do not forward a form to the health department without a test result.)**
30. Check the appropriate confirmatory test result.
31. Check the appropriate (HIV 2 EIA) test result.

Pre-Test Information

This information should be filled in to the best of the client's memory. If they are unable to remember the exact day, month, and year, please complete as much as they can remember.

32. Check the circle that corresponds with previous HIV test results. If client had no previous HIV test, skip 33-37. **Do not count today's test in this section.**
33. Check the circle that corresponds with self reported results.
34. If the client answered "yes" to a previous HIV test, indicate the state.
35. Indicate the day, month and year of the **first positive** HIV test.
36. Indicate the day, month, and year of the **last negative** HIV test.
37. Indicate the number of HIV tests within the last 24 months.

Client Risk Factors

38. Check the client risk factors. Choose only one.
39. Check the circle if risk factors were discussed.
40. Check the circle if a risk reduction plan was developed.
37. If yes, indicate if the client shared injection equipment.
38. Indicate if the client has used non-injection drugs.
39. If yes, list drug of choice.
40. Indicate if a risk reduction plan was developed for the client. **If "no" be sure to complete #42, Client Sexual Risk Factors.**
41. Indicate if the client had vaginal or anal sex in the past 36 months (3 years):
    - With a person who was HIV positive
    - With a person who used injection drugs
    - With a person who has sex with men.
    - Without using a condom

42. Blacken the circle that explains the client sexual risk factors.

Post Test Notification

43. Indicate if test results were provided.
44. Date test results were given to the client.
45. If test results were not provided blacken circle that indicates the reason.

Referrals for HIV+ Clients Only: Centers for Disease Control Required Data

46. Was the client referred to medical care?
47. If "no" indicate why.
48. Did the client attend the first appointment?
49. Was the client referred for HIV Prevention Services?
50. Was the client referred for Partner Counseling & Referral Services (PCRS)?

51. Was the client referred for STD testing?
52. Was the client referred for TB testing?
53. If female, is the client pregnant?
54. If yes, is the client receiving prenatal care?
55. If no, was the client referred for prenatal care?
56. If yes, did the client attend the first prenatal appointment?

SITE CODES

01 - Health Department Clinics other than STD, TB, FP, Mat
02 - Sexually Transmitted Disease (STD Clinics)
03 - Drug Treatment Centers
04 - Family Planning Clinics (FP)
05 - Prenatal/Maternity Clinics (Mat)
06 - Tuberculosis Clinics (TB)
07 - Community Health Centers/Primary Health Care Centers
08 - Prisons/Jails
09 - Hospitals/Clinics/Physicians/Community-based Organizations

COUNTY CODES - Enter 2-digit county code for the provider.

01 - Autauga	18 - Conecuh	34 - Henry	51 - Montgomery
02 - Baldwin	19 - Coosa	35 - Houston	52 - Morgan
03 - Barbour	20 - Covington	36 - Jackson	53 - Perry
04 - Bibb	21 - Crenshaw	37 - Jefferson	54 - Pickens
05 - Blount	22 - Cullman	38 - Lamar	55 - Pike
06 - Bullock	23 - Dale	39 - Lauderdale	56 - Randolph
07 - Butler	24 - Dallas	40 - Lawrence	57 - Russell
08 - Calhoun	25 - Dekalb	41 - Lee	58 - St. Clair
09 - Chambers	26 - Elmore	42 - Limestone	59 - Shelby
10 - Cherokee	27 - Escambia	43 - Lowndes	60 - Sumter

11 - Chilton	28 - Etowah	44 - Macon	61 - Talladega
12 - Choctaw	29 - Fayette	45 - Madison	62 - Tallapoosa
13 - Clark	30 - Franklin	46 - Marengo	63 - Tuscaloosa
14 - Clay	31 - Geneva	47 - Marion	64 - Walker
15 - Cleburne	32 - Greene	48 - Marshall	65 - Washington
16 - Coffee	33 - Hale	49 - Mobile	66 - Wilcox
17 - Colbert		50 - Monroe	67 – Winston

Instructions for submitting the HIV Serology Form to the Division of HIV/AIDS Prevention & Control

Please submit serology information on positive and negative test results in the following format. After the client has been post-test counseled the Control Copy will be completed and sent to the HIV/AIDS Division. The Provider Copy (Pg. 4) should be placed in the client's record. The remaining copies may be shredded. The CONTROL COPY will be forwarded to the attention of Coronda Judkins, HIV/AIDS Division, Suite 1400, 201 Monroe Street, Montgomery, AL., 36104.