INSTRUCTIONS FOR COMPLETING THE
HIV-ab SEROLOGY LAB FORM 2.0
HEALTH DEPARTMENT 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; ensure that the 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 following pretest counseling.

If using *PHALCON* labels for the patient information section, please remember to place a label on all copies of the form.

PATIENT INFORMATION: If using *PHALCON* labels, insure that all requested information is on the *PHALCON* label; place a *PHALCON label* on each of the **four (4)** copies of the form over the "Patient's Last Name." If the PHALCON label has a P O Box address and you are aware of a street address, please place the street address in "Patient's Address."

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 # (Comprehensive Health Record)
6. Patient's Birth Sex
7. Patient's Current Gender
8. Patient's **9 digit** Social Security Number (If the person does not have 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. 4)
14. Patient's Apartment Number
15. Patient's City (No abbreviations)
16. Patient's State
17. Patient's Zip Code
18. Patient's Telephone Number

19. Provider Name
20. Provider Site Code (Pg. 4)
21. Provider County (Pg. 4)
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.
26. Check the square that corresponds to the specimen type.
27. Date test results were received. **(Lab Only)**
28. Date test results were reported to the health department. **(Lab Only)**
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 the 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.
41. Check all risk factors and condom usage for the first three (male, female, transgender).

    Sex with a;

    Male (condoms use, "yes" or "no")

    Female (condom use, "yes" or "no")

    Transgender (condom use, "yes" or "no")

Male Intravenous Drug User (IDU)
Female IDU
Transgender IDU
HIV + male
HIV+ female
HIV+ transgender

42. Check response of female client who had sex with a Man Who Has Sex with Men (MSM)
43. Check in the client has used injection drugs. If "yes" check if the client shared drug injection equipment.
44. Additional Risk Factors (Check all that apply).
    oral sex
    sex with multiple partners
    sex with a person who had an STD
    sex while intoxicated or high
    sex with a person of unknown risk
    sex with an anonymous partner
    sex in exchange for drugs, money or something they needed
    sex with someone who exchanges sex for drugs, money, or something they need
    sex with someone who has hemophilia, or had a transfusion or transplant

Post Test Notification

Results Provided

45. Indicate if test results were provided. If "no" check the reason.
46. If results were provided check the circle.
    Provide the date results were provided.

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

47. Indicate if the client was referred to medical care.
    If "no" check the reason.
48. If the client was referred check the circle.
    Indicate if the client attended the first appointment (if known).
    Indicate if the first appointment was within 90 days after the HIV test.
49. Indicate if the client was referred or contacted by the health department's Disease Intervention Specialist (DIS) for Partner Services.
    If "yes" indicate if the client was interviewed for Partner Services.
50. Indicate if the client was referred to HIV Prevention Services. (HIV Prevention Services can be provided by the testing provider or another provider.)
    If "yes" indicate if the client received the services.
51. Indicate if the client is pregnant.
    If "yes" indicate if the client is receiving prenatal care.

Antiretroviral Therapy

52. Indicate if the client has been prescribed antiretroviral therapy.
    If "yes" indicate what the client is taking.
53. Date the client first used ART.
54. Date the client last used ART.

Testing Consent

55. Indicate if the client agreed to be tested.
56. Enter the date the form was completed.
57. Enter the name of the provider collecting the patient data.

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 county the client resides in at the time the test is given.

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 HIV Serology Data Collection Forms 2.0.

The HIV Serology Form (ADPH-CL-109) is a **four (4)** part form. After completing the form, mail the Control Copy and Post Test Copy to the attention of Gail Johnson or Tamara Foster, Division of HIV/AIDS Prevention and Control, Suite 1400, 201 Monroe Street, Montgomery, AL., 36104.

For more information, questions, or clarification contact the HIV/AIDS Division of Prevention and Control, 334-206-5364.