

**INSTRUCTIONS FOR COMPLETING THE HIV-ab SEROLOGY LAB FORM**  
**(ADPH-CL-109) Revised 6/08**

The revised HIV-ab Serology is designed for scanning into a computer database. The form **must** be completed as instructed to assure accurate information is collected.

**USE BLACK INK AND FILL IN THE SQUARE/CIRCLE COMPLETELY.**

When completing the form by hand, please print legibly.

Please note the following:

The HIV-ab Serology Lab Form is to be completed on each individual who, following pretest counseling, signs informed consent and is tested for HIV-ab. **The (\*) refers to Health Department Employees Only**

If using a ball point pen to complete the form, please press firmly; ensure that the signature comes through on all copies of the form.

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 **five (5)** copies of the form.

**Place label inside the shaded rectangle in the upper left corner. Be sure not to cover the identifying number above the shaded box.**

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

- |   |  |
|---|--|
| 1. Patient's Last Name  | 12. Apartment Number                     |
| 2. Patient's First Name                                       | 13. Patient's City, No Abbreviations     |
| 3. Patient's middle initial                                   | 14. Patient's State                      |
| 4. Date of Birth (Month, day, year – xx/xx/xxxx)              | 15. Patient's Zip Code                   |
| 5. CHR Number (Comprehensive Health Record *)                 | 16. Patient's Telephone                  |
| 6. Patient's Sex (Male=1, female=2, Transgender=3, Unknown=4) | 17. Provider Name                        |
| 7. <b>Patient's 9-digit Social Security Number!!</b>          | 18. <b>Provider Site Code (Pg. 3)</b>    |
| 8. Date Specimen Collected (Month, day, year – xx/xx/xxxx)    | 19. <b>Patient's County Code (Pg. 3)</b> |
| 9. Ethnicity (Choose one – fill in box)                       | 20. Provider Zip Code                    |
| 10. Race (Choose one – fill in box)                           | 21. Provider Address                     |
| 11. Patient's Address or Post Office Box Number               | 22. Provider City                        |

### **Test Technolgy**

23. Blacken the square that corresponds to the test technology.
24. Blacken the square that corresponds to the specimen type.
25. Date test results were received.
26. Blacken the appropriate test results.
27. Date test results were reported to the health department.

### **Additional Pre-Test Information**

28. Blacken circle that corresponds with previous HIV test results.
29. Blacken circle that corresponds with self reported results.
30. Date of the last HIV test.
31. Date of the first HIV test.
32. Date of the last negative HIV test.
33. Number of test in the last 12 months.

### **Client Risk Factors**

34. Indicate if client engaged in vaginal, anal or oral sex with a male.
35. Indicate if client engaged in vaginal, anal or oral sex with a female.
36. Indicate if the client had injected drugs.
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.
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: 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?

57. PHALCON Label\*

**All clients must have provided consent for HIV testing. All clients have the right to “opt out” of HIV testing.**

**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 - Lamar	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 specimen and form to the lab.  
(\*HEALTH DEPARTMENT ONLY or Clinics using the Alabama State Lab for  
processing blood specimens.**

The HIV SEROLOGY form (ADPH-CL-109/Rev. 06-00) is a **five (5)** part form. After completing the form, remove the **last two (2)** copies (PROVIDER and POST-TEST).

\*These two copies are to remain in either the client's CHR folder, or in a "tickler" file.

The remaining three copies (CONTROL, LABORATORY and REPORT) are to be mailed with the specimen to the Alabama State Laboratory. **NOTE: This does not apply when using Orasure or rapid test.**

Ensure that the client's name and the pre-printed ID Number are **legibly printed** on the blood tube.

Once the laboratory has run the HIV-ab test, the test results will be marked on the three copies of the HIV SEROLOGY form. The CONTROL COPY will be forwarded to the HIV/AIDS Division, Suite 1400, 201 Monroe Street, Montgomery, AL., 36104.

\* The LABORATORY COPY will be retained by the laboratory for their records and the REPORT COPY will be returned to the Provider.

\*The REPORT COPY with the results of the HIV-ab test will be placed in the Lab Report section of the client's CHR, according to CHR instructions.

After the client has been post-test counseled, or if not post-test counseled, 30 days after the date of the test, the Control Copy will be completed and sent to the HIV/AIDS Division. If the client comes in after the Control Copy has been sent, send in the post test copy after the counseling has been completed.

Orasure label is to be placed in the upper right hand corner of the form.