Louisiana Office of Public Health STD/HIV Testing Form—Part 1

revised April 2012

Date of Session/Visit M M D D Y Y Y Y

Place StarLIMS label here

How did you find out about this service?

PNUMBER

Agency and Site Information

Agency ID:

Site ID :

Site Type: F -

Client/Patient Information

Last Name:

First Name:

Address:

City: State: Zip :

Parish: Phone:

Email:

Date of Birth M M D D Y Y Y Y

Hispanic/Latino Ethnicity?

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)?

☐ American IND./AK Native
☐ Asian
☐ Black/African American
☐ Native HI/Pac.Islander
☐ White
☐ Don't Know
☐ Other:_____

Assigned Sex at Birth?

☐ Male ☐ Female

Current Gender Identity?

☐ Male
☐ Female
☐ Transgender

Ever Tested for HIV in the Past?

☐ Yes → If Yes, what is the client's self Reported Result?
☐ No
☐ Don't Know
☐ Not Asked

☐ Negative ☐ Don't know
☐ Positive ☐ Declined
☐ Preliminary Positive
☐ Indeterminate

Special Use Fields

Other Session Activities	Local Use Field
1. -	L1

	Test 1	Test 2	Test 3
Sample Date	M M D D Y Y Y Y	M M D D Y Y Y Y	M M D D Y Y Y Y
Worker ID			
Test Election	☐ HIV ☐ Syphilis ☐ GC/CT ☐ Other:_____	☐ HIV ☐ Syphilis ☐ GC/CT ☐ Other:_____	☐ HIV ☐ Syphilis ☐ GC/CT ☐ Other:_____
Specimen type	☐ Urine ☐ Venipuncture ☐ Oral mucosal/ pharyngeal ☐ rectal	☐ Urine ☐ Venipuncture ☐ Oral mucosal/ pharyngeal ☐ rectal	☐ Urine ☐ Venipuncture ☐ Oral mucosal/ pharyngeal ☐ rectal
Test Technology	☐ Conventional ☐ Rapid Type:	☐ Conventional ☐ Rapid Type:	☐ Conventional ☐ Rapid Type:
Test Result	☐ Positive/Reactive ☐ Negative ☐ Invalid ☐ Indeterminate	☐ Positive/Reactive ☐ Negative ☐ Invalid ☐ Indeterminate	☐ Positive/Reactive ☐ Negative ☐ Invalid ☐ Indeterminate
Result Provided	☐ Yes ☐ No ☐ Yes, client obtained results from another agency	☐ Yes ☐ No ☐ Yes, client obtained results from another agency	☐ Yes ☐ No ☐ Yes, client obtained results from another agency
If Results NOT provided, why?	☐ Declined Notification ☐ Did not return/ Could not locate ☐ Other	☐ Declined Notification ☐ Did not return/ Could not locate ☐ Other	☐ Declined Notification ☐ Did not return/ Could not locate ☐ Other

In the past 12 months has the client engaged in the following behaviors:

With a...	Man	Woman	Transgender
Vaginal or anal, insertive or receptive sex	☐	☐	☐
...without using a condom?	☐	☐	☐
...with someone who injects drugs?	☐	☐	☐
...with anonymous/causal/internet partner?	☐	☐	☐
...with someone living with HIV infection?	☐	☐	☐
...with a man who has sex with other men?	☐	☐	☐
Oral sex, insertive or receptive?	☐	☐	☐

Has the client injected drugs, vitamins, hormones, steroids, or other medications? ☐ Yes

If yes, did client share drug injection equipment? ☐ Yes

Additional Risk Factor(s) 1 2

PNUMBER	PNUMBER	PNUMBER	PNUMBER	PNUMBER	PNUMBER

NO/AIDS CTR Confirmatory Intake

- Today's Date ____/____/____
- Testing Site_____
- P Number _____
- Confirmatory test done (check if done) ☐
- Client's First Name _____
- Client's Age _____
- Client's Last 4 of social security number plus birth month
  — — — — — —
- Is Client 13-24 years old? Yes / No
  - If YES, offer client ACT Services. Check box if client signed release: ☐
- Client's Phone: _____

  Is this their personal phone number? Yes / No

  Is it okay to leave a voice message? Yes / No

  Is it okay to send a text message? Yes / No
- Client's Email: _____

  Is this their personal email address? Yes / No

  Is it okay to send an email? Yes / No

IF NOT, HOW SHOULD WE CONTACT CLIENT FOR FOLLOW UP?

INSTRUCTIONS:

- Complete all sections on this form, answering each question as the client allows.
- Make sure client signs back of referral form so that we can contact them.

Counselor Name _____

Counselor Contact Info: _____

The Next Steps...

- ☐ Ashley King, our Patient Navigator, will contact you within 72 hours. **It is important that you see an HIV specialist as soon as possible**, and Ashley will help you pick a doctor and set up your first appointment. She can also answer any questions or concerns that you might have right now.

- ☐ You can call or text Ashley at 504-418-5640, or email her at ashleyk@noaidstf.org. Her office is located at 2601 Tulane Ave, Suite 500. You are welcome to visit any time Monday - Friday, 8:30 AM – 5 PM. Give her a call if you want to stop by! ☺

- ☐ Consider your options for support. We offer many support groups, as well as counseling services. Our therapists can see you regardless of whether you have health insurance. There are also support options in the community that we can help you access.

- ☐ One of the most important things to do in the coming weeks is to take good care of your mind and body, and learn about the medical and support services available to you. Below are some online resources for people who have just found out they are HIV+, and for those who are already living with HIV:
  http://aids.gov/hiv-aids-basics/
  www.thebody.com
  www.poz.com

Please feel free to reach out and get in touch.
We're here to support you and help you stay healthy!

Main Office
2601 Tulane Avenue, Suite 500
New Orleans, LA 70119
504-821-2601

Frenchmen St./CAN Office
507 Frenchman St.
New Orleans, LA 70116
504-945-4000

The Movement Office
2610 Esplanade Ave Suite 2B
New Orleans, LA 70119
504-267-4577

REFERRAL FOLLOW-UP FORM

INTERVENTION
MPowerment
Outreach
SGS
Risk Mgmt
Wellness Center
CTRS / HIV SCREENING
HIV Partner Services
Other_____

_____
Referring Agency

Affix CT sticker or write P number

Client Name:		Client Phone:	Client UIN: F¹F³L¹L³MMDDYYYYG **

	Referral # 1 ___/___/___ Date issued / Worker #	Referral # 2 ___/___/___ Date issued / Worker #	Referral # 3 ___/___/___ Date issued / Worker #
Referral Type Code			
Receiving Agency Name, Phone/FAX			
Follow-Up Attempts	Referral # 1	Referral # 2	Referral # 3
1st Attempt	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome
2nd Attempt	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome
3rd Attempt	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome	Date / Worker # / Verify / Outcome
Comments			
Referral Closing*	___/___/___ Date / Final Outcome	___/___/___ Date / Final Outcome	___/___/___ Date / Final Outcome

Verify Codes

V1	Client – Phone contact
V2	Client – In-person contact
V3	Receiving Agency contact
V4	Client – Other contact (email)

Outcome Codes

O1	Pending
O2	Confirmed – accessed (attended first appt.)
O3	Confirmed – did not access
O4	Lost to follow-up
O5	No follow up

If client is HIV+ and a referral to medical care was not made, please indicate reason:

- ☐ Client already in care
- ☐ Client declined care
- ☐ Other: _____

** Client UIN Code:
F1: First letter of first name
F3: Third letter of first name
L1: First letter of last name
L3: Third letter of last name
MMDDYYYY: Birthdate
G: Gender (1-male, 2-female, 3-transgender)

All referrals should be closed as Lost to Follow-up after 60 days if there is no confirmation by client or agency that client accessed e service.

Keep a copy of this form on file in your office and mail in the original.

REFERRAL FOLLOW-UP FORM

REFERRAL TYPE AND CODE

Code	Type	Code	Type
01	HIV Testing	14	Partner Services
02	HIV Confirmatory Testing	15	Mental Health Services
03	HIV Prevention Counseling	16	Comprehensive Risk Counseling Services (Risk Management)
04	STD Screening & Treatment	17	Other prevention services
05	Viral Hepatitis Screening and treatment	18	Other support services
06	Tuberculosis Testing	19	Case Management
07	Syringe Exchange Services	88	Other
08	Reproductive Health Services	89	Hepatitis Vaccination
09	Prenatal Care	90	Mpowerment Program
10	HIV Medical Care	91	Small Group Session Program
11	IDU Risk Reduction Services	92	Wellness Center
12	Substance Abuse Services	93	Needle Availability
13	General Medical Care	94	Housing Services

Consent to Follow up with Receiving Agency

I hereby consent to the release of appointment confirmation between:

_____ and
Referring agency

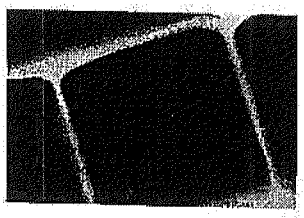
_____.
Receiving agency

The only information to be shared is confirmation of the date that I came to the receiving agency in response to a referral. This information is confidential and is only to be used to improve and coordinate services. I understand that this consent is for a 60-day period from the date of my signature and I can revoke this consent at any time.

_____ _____
Client Signature *Date*

*All referrals should be closed as Lost to Follow-up after 60 days if there is no confirmation by client or agency that client accessed the service.

Keep a copy of this form on file in your office and mail in the [illegible]



Partner Counseling and Referral Services (PCRS)

Are you positive for HIV & wondering how to tell your partner?
Feeling scared & wondering how to protect those that you've been with?

Talking with your partner about HIV can be easier than you think.

We can help. We have counselors who can talk with you about ways to tell your partner about your HIV results. And it is all private & confidential.

We DO NOT share your personal medical, social or sexual information with anyone else.

PCRS is a service that helps people who are HIV-positive (those living with HIV or AIDS) talk to their current or past partners, who may have been exposed to HIV.

PCRS is free, voluntary, and confidential.

PCRS Counselors can:

- Listen to your concerns about telling your partner;
- Be there to answer questions and to offer options;
- Give referrals to medical care & other services;
- Most importantly, they will respect & protect your privacy.

How Can Your Partner Be Told?

- **You can do it.** A counselor can help prepare you to talk to your partner.
- **We can do it with you.** You can choose to talk with your partner with a counselor.
- **We can do it for you.** A counselor can take information you give and then someone from the health department will contact your partner and let them know of their possible exposure.
- **You can combine these options.** You can work with the counselor to come up with a combination of ways to tell your partners.

PCRS is an on-going service. If you should ever need assistance in notifying future partners of their exposure, you can access PCRS again.

You care about your partner. So do we. Should your test come back positive, your local health department will contact you or you can contact them.

Region I STD 504.565.2540

State of Louisiana
Office of Public Health
HIV/AIDS Program

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

FOR CLIENTS UNDER 25 YEARS OLD

This authorizes NO/AIDS Task Force and Connect to Protect Adolescent Care Team (A.C.T.) to release/obtain information as described below.

1. Client Name: _____

Address of client: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Date of Birth: _____

SSN # ____ ____ ____

I, _____, authorize –
Please print name

Name of Agency: Connect to Protect Adolescent Care Team (A.C.T.)
Address: 1440 Tulane Avenue, TW-42
City: New Orleans State: LA Zip Code: 70112
Telephone Number: (504) 988-6488 Fax Number: (504) 988-3619

AND

Name of Agency: NO/AIDS Task Force
Address: 2601 Tulane Avenue Suite 500
City: New Orleans State: LA Zip Code: 70119
Telephone Number: 504-821-2601 Fax Number: 504-821-2040

to communicate with and disclose to one another information regarding my medical care.

Expiration. Your permission will expire 180 days (6 months) after you sign this form unless you indicate otherwise.

Understanding this Authorization

- This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.

- I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by NO/AIDS Task Force, see its *Notice of Privacy Practices* for instructions how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.

- Information released by NO/AIDS Task Force may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. NO/AIDS Task Force will protect information it obtains as required by federal privacy laws.

- I understand my permission is voluntary and I/my child will receive services whether or not I sign this form.

Signature. By signing, I understand that I am authorizing NO/AIDS Task Force to release/obtain information as described above.

Signature_____ Date_____

Print Name_____

Relationship to client: _____

HIV Incidence

Worker ID: _____

Date client reported information: M M D D Y Y Y Y

Has the client ever had a previous positive HIV Test?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Declined

Date of first positive HIV Test: M M D D Y Y Y Y

Has the client ever had a negative HIV Test?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Declined

Date of last negative HIV Test: M M D D Y Y Y Y

Number of negative HIV tests within 24 months before the current (or first positive) HIV test:

- ☐ Don't Know
- ☐ Declined

Has the client used or is client currently using antiretroviral medication (ARV)?

- ☐ Yes → If yes, specify antiretroviral medications

  1 _____ 3 _____

  2 _____ 4 _____

  (see codes from right hand column)
- ☐ No
- ☐ Don't Know
- ☐ Declined

Date ARV began: M M D D Y Y Y Y

Date of most recent ARV use: M M D D Y Y Y Y

STD/HIV Test Form-Part 2

22	Agenerase (amprenavir)
30	Aptivus (tipranavir, TPV)
32	Atripla (efavirenz/emtricitabine/tenofovir DF)
24	Combivir (lamivudine/zidovudine,3TC/AZT
38	Complera (emtricitabine,rilpivirine/tenofovir DF, FTC/RPV/TDF)
06	Crixivan (indinavir, IDV)
37	Edurant (rilpivirine, RPV)
11	Emtriva (emtricitabine, FTC)
03	Epivir (lamivudine, 3TC)
28	Epzicom (abacavir/lamivudine, ABC/3TC)
25	Fortovase (saquinavir, SQV)
10	Fuzeon (enfuvirtide, T20)
19	Hepsera (adefovir)
02	Hivid (zalcitabine, ddC)
23	Hydroxyurea
18	Invirase (saquinavir, SQV)
34	Intelence (etravirine)
36	Isentress (raltegravir)
16	Kaletra (lopinavir, ritonavir)
31	Lexiva (fosamprenavir, 908)
07	Norvir (ritonavir, RTV)
33	Prezista (darunavir,DRV)
09	Rescriptor (delavirdine, DLV)
26	Retrovir (zidovudine, ZDV,AZT)
15	Reyataz (atazanavir, ATV)
08	Saquinavir (Fortavase,Invirase)
35	Selzentry (maraviroc)
21	Sustiva (efavirenz, EFV)
13	Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT
27	Truvada (tenofovir DF/emtricitabine, TDF/FTC
01	Videx (didanosine, ddl)
14	Videx EC (didanosine, ddl)
17	Viracept (nelfinavir, NFV)
05	Viramune (nevirapine, NVP)
12	Viread (tenofovir DF, TDF)
04	Zerit (stavudine, d4T)
20	Ziagen (abacavir, ABC)
89	Other
99	Unspecified

STD/HIV Test Form-Part 2: CDC requires the following for positive tests

Was client referred to:

HIV medical care?	☐ Yes	☐ No
Partner Services?	☐ Yes	☐ No
HIV Prevention Services?	☐ Yes	☐ No

If female, is client pregnant?

☐ Yes	**If yes, is client in prenatal care?**
☐ No	☐ Yes
☐ Don't Know	☐ No
☐ Declined	☐ Don't Know
☐ Not Asked	☐ Declined
	☐ Not Asked

What was the client's housing status in the past 12 months? (check all that apply)

☐ Homeless	☐ Stably Housed
☐ Unstably Housed and at Risk of Losing Housing	☐ Not Asked
	☐ Declined to Answer
	☐ Don't know

Place P label from STD/HIV Form-Part 1 in the space provided below.

Worker ID: _____