This document addresses requirements for conducting Dual Rapid (or "Rapid/Rapid") HIV testing in all agencies funded by The Ohio Department of Health HIV Prevention Program as well as those agencies' sub-grantees. External agencies may choose to adopt this protocol or use it to inform their testing practices.

In a concerted national effort to expedite client linkage to care and improve health outcomes, Ohio's HIV Prevention program has implemented a dual rapid algorithm for HIV testing. Rapid HIV testing, sometimes referred to as "point-of-care (POC)" testing allows clients who test positive for HIV to be promptly linked to care.

Prompt linkage to HIV treatment and care leads to improved health outcomes and reduction of community viral load, which can reduce the number of new HIV infections.

Dual rapid algorithms:

- Utilize one POC test to detect antibodies and a second comparable POC test, from a separate manufacturer, to confirm this detection at a 100% positive-predictive-value.
- Allow clients to receive same-day confirmation of their positive HIV test result and further advances the engagement of populations infected with HIV.
- Remove common barriers including the need for additional laboratory testing and losing clients to follow-up.

In a dual rapid algorithm, both confidential and anonymous testing may be offered. Confidential testing should be encouraged as standard practice. Anonymous testing should never be utilized when conducting the second rapid test. All paper work needed to make an initial appointment with an infectious disease doctor will be given during the single testing event. No return visit for a confirmatory result will be needed.

Test 1 - Conduct the initial HIV rapid test (T1) using whole-blood fingerstick method and following manufacturer guidelines of the device. May be confidential or anonymous.

Initial Rapid Negative-

1. Read result of the initial HIV test (T1)
2. Give result to client
   a. In the case of possible acute infection, refer to lab or medical provider for RNA testing.
      i. Questions for acute infection include: When was your last test? What was the result? In the last three months, is there a moment you are concerned about?
   b. In the case of potential exposure within 72 hours, refer for post-exposure prophylaxis (nPEP) and connect to Patient Assistance Programs for payment support.
3. Complete risk reduction plan; provide the client with information on pre-exposure prophylaxis (PrEP), condoms, and other prevention resources.
4. Recommend re-testing based on risk, behaviors, and window period.
5. Re-enforce risk reduction plan.
6. Close session.
7. Record testing information on Op-scan 1.

Initial Rapid Positive-

1. Give result of first HIV test (T1) to client, let the client process result as needed.
2. Answer any questions, reminding client that another rapid test will be performed immediately.
3. Take sample and run second HIV test (T2).
4. Prepare for discussion of rapid linkage to care.

Test 2 - Conduct the second HIV rapid test (T2) using whole-blood fingerstick method and following manufacturer guidelines of the device. T2 should not be offered anonymously.

Second Rapid Positive-

1. Provide the positive test results of T2 to client.
2. Once the positive test results have been disclosed to the client, offer same-day linkage to care or provide an active referral to care.
3. To provide verification of HIV positive test results for a medical provider, complete the ODH HIV Verification Form.
4. To fulfill mandated reporting requirements, complete Opscan 1 and 2 with complete information, including the required client contact information.

Second Rapid Negative-

1. If the second rapid test (T2) is negative, this is a discordant result; consider retesting to account for potential test failure.
   a. If acute infection is possible, refer to medical care, third-party lab, or regional Linkage to Care Coordinator for connection to care.
   b. If acute infection is unlikely, schedule for additional follow-up testing in 1-2 weeks.
2. To fulfill mandated reporting requirements, complete Opscan 1 and 2 with complete information, including the required client contact information.

HIV Testing Crosswalk - This is a resource that can be used during every testing event that walks HIV test counselors through any potential testing outcome. It also includes reporting requirements for each outcome.

1st Rapid Test Positive

Refuses 2nd Rapid

Data
- Record on Op-scan 1
- Provide Steps Guide

Reporting
- Provide Steps Guide

Data
- Record on Op-scan 1
- Consent Form
- Complete Risk Reduction Plan

Reporting
1. Fax Op-scan 1 to ODH

2nd Rapid Negative

Data
- Record on Op-scan 1;
- Record contact information on Op-scan 2
- Provide Steps Guide

Possible acute?
Refer to provider for follow-up testing

Acute unlikely?
Schedule for follow-up Rapid Testing

Reporting
1. Fax discordant Op-scan 1 & 2 with completed client information to ODH

2nd Rapid Positive

Data
- Complete HIV Verification Form
- Record on Op-scan 1
- Begin Op-scan 2

Requests Referral to Care

Data
- Recorded on Op-scan 2

Requests Rapid Linkage to Care

Data
- Recorded on Op-scan 2

Reporting and Linkage
1. Reporting –FAX Op-scan 1 & 2 with completed client information to ODH
2. Notify regional DIS Supervisor
3. Inform client that someone from the health department will be contacting them
4. ODH enters data into ODRS for DIS/LTC assignment

1st Rapid Test Negative

Data
- Record on Op-scan 1
- Consent Form
- Complete Risk Reduction Plan

Possible acute?
- Explain window period
- Refer to provider for follow-up testing

Acute unlikely?
- Explain window period
- Schedule next testing appointment

Reporting
1. Reporting – testing sites mail or fax batches (≥ 50) of Op-scan 1s with completed client information to ODH regularly (≤ 1 monthly)
2. ODH enters testing data into Evaluation Web for CDC reporting.

Inventory of Required Testing Documents

Every tester should have these forms available for each test:
- Consent Form
- Op-scan 1
- Risk Reduction Plan
- Op-scan 2
- HIV Verification Form
- Steps Guide

ODH HIV Prevention Fax: 614.728.0876
ODH HIV Prevention Phone: 614.995.5599

HIV Verification Form – This form is documentation of two positive rapid HIV tests conducted at a testing site.

1. Keep a copy in the client's file and give the client the original form.
2. Notify your regional DIS supervisor of a client with two positive rapid tests.
3. Assist client with rapid linkage.

HIV VERIFICATION FORM
CONFIDENTAL

This form should be provided to a medical or service provider chosen, by the client, to verify they have received two reactive rapid HIV test results.

LAST NAME		FIRST NAME	
PHONE		GENDER	D.O.B.
COLLECT DATE		TIME	

1st Rapid Test _____   Negative ☐   Positive ☐

2nd Rapid Test _____   Negative ☐   Positive ☐

TEST SITE _____

CITY	PHONE
TESTER NAME	CTR TESTING #

TESTER SIGATURE _____

Rapid HIV testing considerations:
- If the 1st rapid test is **NEGATIVE**, the screen is considered negative for HIV antibodies
- If the 1st rapid test is **POSITIVE**, confirmatory testing (molecular tests) from an outside laboratory or a second rapid test is recommended.
  - If two different rapid tests have been performed and are **both POSITIVE**:
    - Based on current CDC guidelines, the patient is **considered positive for HIV and has been referred for care**. Additional testing may be performed by the provider to evaluate for treatment options.
  - If two different rapid tests have been performed with the **second test NEGATIVE**:
    - The results are **DISCORDANT** and require further investigation. Refer to an outside laboratory or provider for confirmatory testing; recommend follow-up testing in 1-2 weeks; or provide rapid linkage for confirmatory.

Rapid/Rapid HIV Testing Protocol

Op-scan 1 - Op-scan 1 is completed for every HIV test, including tests that are negative.

1. Negative test results may be mailed or faxed to ODH in batches at least monthly.
2. Positive test results should be recorded on Op-scan 1 and faxed with Op-scan 2 and completed contact information to ODH as soon as possible.

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
	HIV Test 1								HIV Test 2								HIV Test 3							
Worker ID																								
Test Election	☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing								☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing								☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing							
Test Technology	☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other								☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other								☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other							
Test Result	☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result								☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result								☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result							

Op-scan 2 - Op-scan 2 is only completed for HIV positive test results or discordant test results.

1. Include client name and preferred method of contact for DIS/LTC to follow-up.
2. Indicate if client had same-day medical visit or same-day referral.
3. Fax Op-scan 1&2 to ODH as soon as possible. You may update Op-scan 2 if circumstances change; refax to ODH if this occurs.

Client Name_____   EVALUATIONWEB® 2017 HIV TEST TEMPLATE

Contact Info:_____   **PART TWO**

Enter or adhere Form ID

CDC requires the following information on all preliminary and confirmed HIV-positive clients:		Local Use Fields					
Was the client referred to HIV medical care?		L5	#	#	#	#	#
☐ No →	Reason the client not referred to HIV Medical Care? ☐ Client Already in Care ☐ Client Declined Care	L6	#	#	#	#	#
		L7	#	#	#	#	#
☐ Yes →	Did the client attend the first appointment?	L8	#	#	#	#	#
☐ Don't Know	☐ Pending ☐ Confirmed: Accessed Service → ☐ Confirmed: Did Not Access Service ☐ Lost to Follow-Up ☐ No Follow-Up ☐ Don't Know	Date client attended first HIV medical care appointment: M M D D Y Y Y Y	L9	#	#	#	#	#
			L10	#	#	#	#	#
	Rapid Linkage		L11	#	#	#	#	#
	○ Same Day Medical Visit	First medical appointment within 30 days of the HIV test?	L12	#	#	#	#	#
	○ Same Day Referral	☐ No ☐ Yes ☐ Don't Know	L13	#	#	#	#	#
	Agency/Facility:_____		L14	#	#	#	#	#
	Provider Name: _____		L15	#	#	#	#	#

Required Testing Documentation – These documents should be present in every testing event. Each document is provided here.

- Consent Form
- Risk Reduction Plan
- Op-scan 1
- Op-scan 2
- HIV Verification Form

ODH HIV Prevention Testing Crosswalk

1st Rapid Test Positive			
1st Rapid Test Positive Data Record on Op-scan 1 Consent Form Complete Risk Reduction Plan	**Refuses 2nd Rapid** Data Record on Op-scan 1 Provide *Steps* Guide **Reporting** 1. Fax Op-scan 1 to ODH	**Inventory of Required Testing Documents** Every tester should have these forms available for each test: • Consent Form • Op-scan 2 • Op-scan 1 • HIV Verification Form • Risk Reduction Plan • *Steps* Guide ODH HIV Prevention Fax: 614.728.0876 ODH HIV Prevention Phone: 614.995.5599	
	2nd Rapid Negative Data Record on Op-scan 1; Record contact information on Op-scan 2 Provide *Steps* Guide	**Possible acute?** Refer to provider for follow-up testing **Acute unlikely?** Schedule for follow-up Rapid Testing	**Reporting** 1. Fax discordant Op-scan 1 & 2 with completed client information to ODH
	2nd Rapid Positive Data Complete HIV Verification Form Record on Op-scan 1 Begin Op-scan 2	**Requests Referral to Care** Data Recorded on Op-scan 2 **Requests Rapid Linkage to Care** Data Recorded on Op-scan 2	**Reporting and Linkage** 1. **Reporting –FAX Op-scan 1 & 2 with completed client information to ODH** 2. Notify regional DIS Supervisor 3. Inform client that someone from the health department will be contacting them 4. ODH enters data into ODRS for DIS/LTC assignment

1st Rapid Test Negative		
1st Rapid Test Negative Data Record on Op-scan 1 Consent Form Complete Risk Reduction Plan	**Possible acute?** • Explain window period • Refer to provider for follow-up testing **Acute unlikely?** • Explain window period • Schedule next testing appointment	**Reporting** 1. **Reporting** – testing sites **mail or fax** batches (≥ 50) of Op-scan 1s with completed client information to ODH regularly (≤ 1 monthly) 2. ODH enters testing data into Evaluation Web for CDC reporting.

Consent Form – Rapid HIV Test

What is HIV? HIV stands for *human immunodeficiency virus*, it attacks your body's immune system, which makes it harder to fight infections. Without treatment, it can lead to *acquired immunodeficiency syndrome* (AIDS). There is no cure for HIV; once you get it, you have it for life.

How Do People Get HIV? In the United States, HIV is spread mainly by:

1. Having anal or vaginal sex with someone who has HIV without using a condom or taking medicines to prevent or treat HIV.
   o For the HIV-negative partner, receptive anal sex (bottoming) is the highest-risk sexual behavior, but you can also get HIV from insertive anal sex (topping).
   o Either partner can get HIV through vaginal sex, though it is less risky for getting HIV.
2. Sharing needles or syringes, rinse water, or other equipment (works) used to prepare drugs for injection with someone who has HIV. HIV can live in a used needle up to 42 days depending on temperature and other factors.

How is an HIV Test Done? A sample of your blood is tested for antibodies. If the test is positive, more tests are done on the same sample to make sure the first test was right. If the other tests come back positive, you are considered to be infected.

What Does a Positive Test Mean? A positive test does NOT mean you have AIDS. It is important to start medical care and HIV treatment as soon as possible. Antiretroviral therapy (ART), medicines to treat HIV, is recommended for all people with HIV, no matter how long they've had it or how healthy they are. ART slows down HIV and helps protect you. When taken the right way, ART can keep you healthy and lowers your chance of passing HIV to your sex or drug partner(s).

- If you test positive, tell health department staff about anyone you've had sex or shared needles with so they can also get an HIV test. Your name will NOT be used.
- The law requires that positive HIV tests be reported to the Ohio Department of Health.

What Does a Negative Test Mean? It means no HIV antibodies were found, but you could still have HIV. That's because of the window period—the time between when a person gets HIV and when a test can find it. The window period varies from person to person and by the type of HIV test. Depending on your risk, you may need to take another test in the next 30-90 days.

You Have a Choice: You can choose NOT to take this test at any point.

- You can test **confidentially**, which means you get a copy of your results with your name on it. Your test results cannot be given to anyone unless you say so.
- You can test **anonymously**, which means your name will not be used. If you choose anonymous, you cannot get a copy of your results.

Please Ask Questions! If you have any questions about this test, please ask a doctor, a counselor or call the Ohio HIV/STI Hotline at 1-800-332-2437.

I have read the above, or have had it read to me, and I agree to be tested for HIV.

Name _____   Date _____

Prepared under the authority of Ohio Revised Code 3701.242 (A) (3)

Risk Reduction Plan

Last Name: _____ **First Name:** _____ **Date:** ____/____/____ **Site:** _____

RISK AWARENESS

Knowledge Awareness:
- Have you ever been tested before?
- What have you heard about HIV?
  - …about how people can get HIV?
  - …about how people can avoid HIV?

Cost / Benefits Analysis:
- What's working for you with what you are doing now?
- What are you doing now that you would like to change?
- What is the hardest (most difficult) part of changing?
- What might be good about changing?

Significance to Self:
- What is the reason for getting tested for HIV?
- What if your testing is positive?
- If negative, how will you continue to remain so?

Capacity Building:
- What will be the most difficult part of this for you?
- How have you handled a similar situation in the past?
- What will you need to do differently?
- When will you do this? What words will you use?

RISK PERCEPTION

Client: (high) 5 4 3 2 1 (low)

Counselor: (high) 5 4 3 2 1 (low)

RISK REDUCTION PLAN

Plan Process: 1. List steps client is willing to take to reduce risk.
2. Clarify cost and benefits of the plan and adjust as needed.

_____

_____

_____

_____

_____

_____

RISK REDUCTION STRATEGIES
- ϒ Talk to a medical provider about PrEP
- ϒ Try to limit number of partners
- ϒ Ask current or future partner(s) to be tested (a partner who respects you will get tested)
- ϒ Use condoms (or try to increase the frequency of condom use.)
- ϒ Get to know future partners better before having sex
- ϒ Ask partners about sexual history (ex. have you ever had a sexually transmitted disease?)
- ϒ Don't have sex when your judgment could be impaired. (ex. with use of alcohol or drugs)
- ϒ Try not to share drug equipment

EDUCATION, PREVENTION & FOLLOW-UP

Materials Given: ☐ HIV/STI Info ☐ ESL HIV/STI Materials ☐ PrEP Info ☐ Dental Dams/Misc.
☐ Condoms ☐ Receptive "Female" Condoms ☐ Lube ☐ Demonstration

Follow-up Card Given: ☐ Yes ☐ No **Referral Made:** ☐ Yes ☐ No

Retest Recommended: ☐ Yes ☐ No **Retest Date:** _____/_____/_____

Counselor Name: _____ **#:** _____

HIV Antibody Test Results*: _____

*A negative HIV test result does **not** exclude the possibility of infection with HIV due to the window period.

HIV VERIFICATION FORM

CONFIDENTAL

This form should be provided to a medical or service provider chosen, by the client, to verify they have received two reactive rapid HIV test results.

LAST NAME	FIRST NAME	
PHONE	**GENDER**	**D.O.B.**
COLLECT DATE	**TIME**	

1ˢᵗ Rapid Test _____   Negative ☐   Positive ☐

2ⁿᵈ Rapid Test _____   Negative ☐   Positive ☐

TEST SITE	
CITY	**PHONE**
TESTER NAME	**CTR TESTING #**
TESTER SIGATURE	

Rapid HIV testing considerations:
- If the 1st rapid test is **NEGATIVE**, the screen is considered negative for HIV antibodies
- If the 1st rapid test is **POSITIVE**, confirmatory testing (molecular tests) from an outside laboratory or a second rapid test is recommended.
  - If two different rapid tests have been performed and are **both POSITIVE**:
    - Based on current CDC guidelines, the patient is **considered positive for HIV and has been referred for care.** Additional testing may be performed by the provider to evaluate for treatment options.
  - If two different rapid tests have been performed with the **second test NEGATIVE**:
    - The results are **DISCORDANT** and require further investigation. Refer to an outside laboratory or provider for confirmatory testing; recommend follow-up testing in 1-2 weeks; or provide rapid linkage for confirmatory.

For assistance with test interpretation, contact:
Ohio Department of Health/HIV Prevention
246 North High Street, 6th Floor
Columbus, OH 43266-0588
PHONE: 614.995.5599 FAX: 614.728.0876
HIVPrevention@odh.ohio.gov

EVALUATIONWEB® 2017 HIV TEST TEMPLATE

General instructions for completing the EvaluationWeb HIV Test Template

This HIV testing data collection template is provided to assist CDC grantees who are collecting National HIV Prevention Program Monitoring and Evaluation (NHME) HIV testing data. This template is not mandated for use in the field and may be customized so that an agency may make any changes to the template to best fit their needs. Contact the NHME Service Center to receive a Microsoft Publisher version of this template that can be edited (1-855-374-7310 or NHMEservice@cdc.gov).

- Part One—for all CDC-funded testing events

- Part Two—for recording linkage and referral data on all preliminary and confirmed HIV-positive clients

- Part Three—for jurisdictions funded to collect HIV incidence data. These data should be entered into EvaluationWeb.

- **NHM&E Required Additional HIV Test Questions for CDC-Directly Funded CBOs-***Completion of the NHM&E Required Additional HIV Test questions are mandatory for CDC-directly funded CBOs. The required additional HIV Test questions are to be collected per client per testing event.*
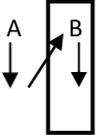
This template is designed for direct data entry into EvaluationWeb. The template follows the EvaluationWeb direct data entry screens beginning from top upper left column A to bottom left, then to upper right column B to bottom right. This template is **not** intended for use as an Optical Character Recognition (OCR) document.

Detailed instructions for completing the EvaluationWeb HIV Test Template

- The fields on this form reflect data requirements as described in the most current NHME Data Variable Set.

- Six data fields are mandatory for a valid testing event: Form ID, Session Date, Program Announcement, Agency ID or CBO agency ID as applicable, Jurisdiction (populated automatically in EvaluationWeb) and Site ID.

- Write in the Form Identification (ID) number or adhere a sticker with the Form ID (barcode) to each data entry page.

- There are three different response formats that you will use to record data: (1) text boxes, (2) check boxes and (3) fill-in ovals. Text boxes are used to write in information (codes and dates). Check boxes and fill-in ovals are used to select only one response, unless otherwise indicated on the template.

- Page 3 lists codes for Site Type, Other Risk Factor(s), and Other Session Activities. Please refer to these codes for entry in Part One.

- For agencies directly entering data into EvaluationWeb, it may not be necessary to complete the fields Agency ID, Site Type, Site County and Site ZIP code as they will be pre-loaded by the system administrator.

- Depending on your jurisdiction you will either write in the name or the identification number for the Agency and Site. In these instances you will want to follow the convention of your jurisdiction. Do not write both the identification number and name for these fields.

- For client county of residence, report the three-digit FIPS code for the county, not the county name.

For assistance with data reporting and submissions

- To add new sites, contact the HELP DESK at Luther Consulting (help@lutherconsulting.com or 1-866-517-6570 option #1).

- For questions about NHME data elements, contact the NHME Service Center (NHMEservice@cdc.gov or 1-855-374-7310).

CDC assurance of confidentiality

The CDC Assurance of Confidentiality statement assures clients and agency staff that data collected and recorded on templates will be handled securely and confidentially. All CDC grantees are encouraged to include the CDC Assurance of Confidentiality statement on all HIV prevention program data collection templates.

Assurance of Confidentiality Statement:

The information in this report to the Centers for Disease Control and Prevention (CDC) is collected under the authority of Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k. Your cooperation is necessary for evaluation of the interventions being done to understand and control HIV/AIDS. Information in CDC's HIV/AIDS National HIV Prevention Program Monitoring and Evaluation (NHME) system that would permit identification of any individual on whom a record is maintained, or any health care provider collecting NHME information, or any institution with which that health care provider is associated will be protected under Section 308(d) of the Public Health Service Act. This protection for the NHME information includes a guarantee that the information will be held in confidence, will be used only for the purposes stated in the Assurance of Confidentially on file at CDC, and will not otherwise be disclosed or released without the consent of the individual, health care provider, or institution described herein in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m(d)).

Left Column

Enter or adhere Form ID

Session Date	M M D D Y Y Y Y

Program Announcement (select only one)

- PS12-1201 Category A
- PS12-1201 Category B
- PS15-1502 Category A
- PS15-1502 Category B
- PS15-1506 PRIDE
- PS15-1509
- PS17-1704 Category A—YMSM
- PS17-1704 Category B—YTG
- OTHER: _____

All CDC-directly funded CBOs must to complete the required additional HIV test questions.

Agency Name/ID Number

Directly Funded CBO Agency ID (For CDC-directly funded CBOs only)

Site Name/ID Number

Site Type (enter type code from page 3)   F # # . # #

Site ZIP Code   # # # # #

Site County (enter 3-digit FIPS code)   # # #

Client ID

Client Record Number (Required for CDC-directly funded CBOs. Numeric only)   # # # # # # # # #

Date of Birth (enter 01/01/1800 if unknown)   M M D D Y Y Y Y

Client State (use USPS abbreviation)

Client County

Client ZIP Code   # # # # #

Client Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Don't Know
- Declined
- Not Asked

Client Race (check all that apply)

- American IN/AK Native
- Asian
- Black/African American
- Native HI/Pac. Islander
- White
- Don't Know
- Declined
- Not Asked

Client Assigned Sex at Birth

- Male
- Female
- Declined
- Not Asked

Client Current Gender Identity

- Male
- Female
- Declined
- Not Asked
- Transgender MTF
- Transgender FTM
- Transgender Unspecified
- Additional (specify): _____

Previous HIV Test?

- No → If Yes, date of last test: mm / dd / yyyy
- Yes

If Yes, what is the client's self-reported result?

- Positive
- Negative
- Preliminary Positive
- Don't Know
- Declined
- Not Asked
- Don't Know
- Declined
- Not Asked

Right Column

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
	HIV Test 1	**HIV Test 2**	**HIV Test 3**

	HIV Test 1	HIV Test 2	HIV Test 3
Worker ID			
Test Election	Anonymously / Confidentially / Test Not Offered / Declined Testing	Anonymously / Confidentially / Test Not Offered / Declined Testing	Anonymously / Confidentially / Test Not Offered / Declined Testing
Test Technology	Conventional / Rapid / NAAT/RNA Testing / Other	Conventional / Rapid / NAAT/RNA Testing / Other	Conventional / Rapid / NAAT/RNA Testing / Other
Test Result	Positive/Reactive / Negative / Indeterminate / Invalid / No Result	Positive/Reactive / Negative / Indeterminate / Invalid / No Result	Positive/Reactive / Negative / Indeterminate / Invalid / No Result
Result Provided	No / Yes / Yes, client obtained results from another agency	No / Yes / Yes, client obtained results from another agency	No / Yes / 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

Choose status of collection of behavioral risk profile

- Client completed a behavioral risk profile
- Client was not asked about behavioral risk factors
- Client was asked, but no behavioral risks identified
- Client declined to discuss behavioral risk factors

For clients completing a risk profile, did the client report the following behaviors in the past 12 months? (select all that apply)

	No	Yes	Don't Know
Vaginal or Anal Sex with a male			
With a male without using a condom			
With a male who is IDU			
With a male who is HIV +			
Vaginal or Anal Sex with a female			
With a female without using a condom			
With a female who is IDU			
With a female who is HIV +			
Vaginal or Anal Sex with a transgender person			
With a transgender without using a condom			
With a transgender who is IDU			
With a transgender who is HIV +			
Injection drug use			
Share drug injection equipment?			
Vaginal or Anal Sex with MSM (female only)			

Additional Risk Factors (enter two-digit code from page 3)	1 # #	2 # #	3 # #	4 # #

Session Activities (enter codes from page 3)	1 # # . # #	3 # # . # #
	2 # # . # #	4 # # . # #

Local Use Fields	L1 # # #	L3 # # #
	L2	L4

Codes for Site Type: CLINICAL	Codes for Site Type: NON-CLINICAL
F01.01 Clinical - Inpatient hospital F02.12 Clinical - TB clinic F02.19 Clinical - Substance abuse treatment facility F02.51 Clinical - Community health center F03 Clinical - Emergency department F08 Clinical - Primary care clinic (other than CHC) F09 Clinical - Pharmacy or other retail-based clinic F10 Clinical - STD clinic F11 Clinical - Dental clinic F12 Clinical - Correctional facility clinic F13 Clinical - Other	F04.05 Non-clinical - HIV testing site F06.02 Non-clinical - Community setting - School/educational facility F06.03 Non-clinical - Community setting - Church/mosque/synagogue/temple F06.04 Non-clinical - Community setting - Shelter/transitional housing F06.05 Non-clinical - Community setting - Commercial facility F06.07 Non-clinical - Community setting - Bar/club/adult entertainment F06.08 Non-clinical - Community setting - Public area F06.12 Non-clinical - Community setting – Individual residence F06.88 Non-clinical - Community setting - Other F07 Non-clinical - Correctional facility - Non-healthcare F14 Non-clinical - Health department - Field visit F15 Non-clinical - Community setting - Syringe exchange program F88 Non-clinical - Other

Codes for Additional Risk Factor(s)

01 Exchange vaginal/anal sex for drugs/money/or something they needed 02 Vaginal/anal sex while intoxicated and/or high on drugs 05 Vaginal/anal sex with person of unknown HIV status 06 Vaginal/anal sex with person who exchanges sex for drugs/money	08 Vaginal/anal sex with anonymous partner 12 Diagnosed with a sexually transmitted disease (STD) 13 Sex with multiple partners 14 Oral sex 15 Unprotected vaginal/anal sex with a person who is an IDU	16 Unprotected vaginal/anal sex with a person who is HIV positive 17 Unprotected vaginal/anal sex in exchange for drugs/money/or something they needed 18 Unprotected vaginal/anal sex with person who exchanges sex for drugs/money 19 Unprotected sex with multiple partners

Codes for Session Activities

04.00 Referral 05.00 Personalized risk assessment 06.00 Elicit partners 07.00 Notification of exposure 08.01 Information – HIV/AIDS transmission 08.02 Information – Abstinence/postpone sexual activity 08.03 Information – Other sexually transmitted diseases 08.04 Information – Viral hepatitis 08.05 Information – Availability of HIV/STD counseling and testing 08.06 Information – Availability of partner notification and referral services 08.07 Information – Living with HIV/AIDS 08.08 Information – Availability of social services 08.09 Information – Availability of medical services 08.10 Information – Sexual risk reduction 08.11 Information – IDU risk reduction 08.12 Information – IDU risk-free behavior 08.13 Information – Condom/barrier use 08.14 Information – Negotiation/Communication 08.15 Information – Decision making 08.16 Information – Disclosure of HIV status 08.17 Information – Providing prevention services 08.18 Information – HIV testing 08.19 Information – Partner notification 08.20 Information – HIV medication therapy adherence 08.21 Information – Alcohol and drug use prevention 08.22 Information – Sexual health 08.23 Information – TB testing 08.88 Information – Other 09.01 Demonstration – Condom/barrier use 09.02 Demonstration – IDU risk reduction	09.03 Demonstration – Negotiation/ communication 09.04 Demonstration – Decision making 09.05 Demonstration – Disclosure of HIV status 09.06 Demonstration – Providing prevention services 09.07 Demonstration – Partner notification 09.88 Demonstration – Other 10.01 Practice – Condom/barrier use 10.02 Practice – IDU risk reduction 10.03 Practice – Negotiation/Communication 10.04 Practice – Decision making 10.05 Practice – Disclosure of HIV status 10.06 Practice – Providing prevention services 10.07 Practice – Partner notification 10.88 Practice – Other 11.01 Discussion – Sexual risk reduction 11.02 Discussion – IDU risk reduction 11.03 Discussion – HIV testing 11.04 Discussion – Other sexually transmitted diseases 11.05 Discussion – Disclosure of HIV status 11.06 Discussion – Partner notification 11.07 Discussion – HIV medication therapy adherence 11.08 Discussion – Abstinence/postpone sexual activity 11.09 Discussion – IDU risk-free behavior 11.10 Discussion – HIV/AIDS transmission 11.11 Discussion – Viral hepatitis 11.12 Discussion – Living with HIV/AIDS 11.13 Discussion – Availability of HIV/AIDS counseling & testing 11.14 Discussion – Availability of partner notification and referral services	11.15 Discussion – Availability of social services 11.16 Discussion – Availability of medical services 11.17 Discussion – Condom/barrier use 11.18 Discussion – Negotiation/communication 11.19 Discussion – Decision making 11.20 Discussion – Providing prevention services 11.21 Discussion – Alcohol and drug use prevention 11.22 Discussion – Sexual health 11.23 Discussion – TB testing 11.24 Discussion - Stage-based encounter 11.88 Discussion - Other 12.01 Other testing – Pregnancy 12.02 Other testing – STD 12.03 Other testing – Viral hepatitis 12.04 Other testing – TB 13.01 Distribution – Male condoms 13.02 Distribution – Female condoms 13.03 Distribution – Safe sex kits 13.04 Distribution – Safer injection/bleach kits 13.05 Distribution – Lubricants 13.06 Distribution – Education materials 13.07 Distribution – Referral lists 13.08 Distribution – Role model stories 13.09 Distribution – Dental dams 13.88 Distribution – Other 14.01 Post-intervention follow-up 14.02 Post-intervention booster session 15.00 HIV testing history survey 16.00 Risk reduction counseling 17.00 Personalized cognitive counseling 88 Other

Client Name_____

Contact Info:_____

Enter or adhere Form ID	

CDC requires the following information on all preliminary and confirmed HIV-positive clients:

	Local Use Fields

Was the client referred to HIV medical care?

L5	# # # # #

⌐ **No** ⟶ Reason the client not referred to HIV Medical Care?
- ⌐ Client Already in Care
- ⌐ Client Declined Care

L6	# # # # #
L7	# # # # #

⌐ **Yes** ⟶ **Did the client attend the first appointment?**

⌐ **Don't Know**

- ⌐ Pending ⟶
- ⌐ **Confirmed: Accessed Service**
- ⌐ Confirmed: Did Not Access Service
- ⌐ Lost to Follow-Up
- ⌐ No Follow-Up
- ⌐ Don't Know

Rapid Linkage

○ Same Day Medical Visit

○ Same Day Referral

Agency/Facility:
_____

Provider Name:
_____

Date client attended first HIV medical care appointment:

M	M	D	D	Y	Y	Y	Y

First medical appointment within 30 days of the HIV test?
- ⌐ No
- ⌐ Yes
- ⌐ Don't Know

L8	# # # # #
L9	# # # # #
L10	# # # # #
L11	# # # # #
L12	# # # # #
L13	# # # # #
L14	# # # # #
L15	# # # # #

Was the client referred to/contacted by Partner Services?

L16	# # # # #

⌐ **No** ⟶

⌐ **Yes**

⌐ **Don't Know**

L17	# # # # #

Was the client interviewed for Partner Services?
- ⌐ No
- ⌐ Yes
- ⌐ Don't Know

Was the client interview within 30 days of receiving their result?
- ⌐ No
- ⌐ Yes
- ⌐ Don't Know

	CDC Use Fields

Was the client referred to HIV Prevention Services?

C3	# # # # #

⌐ **No** ⟶

⌐ **Yes**

⌐ **Don't Know**

C4	# # # # #
C5	# # # # #
C6	# # # # #

Did the client receive HIV Prevention Services?
- ⌐ No
- ⌐ Yes
- ⌐ Don't Know

C7	# # # # #
C8	# # # # #
C9	# # # # #

What was the client's _most severe_ housing status in the past 12 months (check only one)?

- ⌐ Literally Homeless
- ⌐ Unstably Housed or At Risk of Losing Housing
- ⌐ Stably Housed
- ⌐ Not Asked
- ⌐ Declined to Answer
- ⌐ Don't Know

Notes:
_____
_____
_____
_____
_____
_____
_____
_____

If female, is the client pregnant?

⌐ **No**

⌐ **Yes**

⌐ Don't Know
⌐ Declined
⌐ Not Asked

Is the client in prenatal care?
- ⌐ No
- ⌐ Yes
- ⌐ Don't Know
- ⌐ Declined
- ⌐ Not Asked

Prior to the client testing positive during this testing event, was she/he previously reported to the jurisdiction's surveillance department as being HIV-positive?

Enter or adhere Form ID

HIV Incidence (if required by health department)

Date the client reported information M M D D Y Y Y Y

Has the client ever had a previous positive HIV test?
- ⌐ No
- ⌐ Yes
- ⌐ 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?
- ⌐ No
- ⌐ Yes
- ⌐ 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)?
- ⌐ No
- ⌐ Yes ⟶ **Specify antiretroviral medications**
  - 1 # #   3 # #
  - 2 # #   4 # #
  - (see codes from right-hand column)
- ⌐ Don't Know
- ⌐ Declined

Date ARV began M M D D Y Y Y Y

Date of last ARV use M M D D Y Y Y Y

Notes:
_____
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Code	Medication
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)
39	Stribild (elvitegravir/cobicistat/tenofovir/ emtricitabine)
21	Sustiva (efavirenz, EFV)
40	Tivicay (dolutegravir)
13	Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT)
27	Truvada (tenofovir DF/emtricitabine, TDF/ FTC)
01	Videx (didanosine, ddI)
14	Videx EC (didanosine, ddI)
17	Viracept (nelfinavir, NFV)
05	Viramune (nevirapine, NVP)
12	Viread (tenofovir DF, TDF)
04	Zerit (stavudine, d4T)
20	Ziagen (abacavir, ABC)
88	Other
99	Unspecified

NHM&E Required Additional HIV Test Questions for Directly Funded CBOs

Instructions		
Completion of the NHM&E Required Additional HIV Test questions are mandatory for CDC-directly funded CBOs. The required additional HIV Test questions are to be collected per client per testing event.	**Enter or adhere Form ID**	
	Client ID	
	Client Record Number Required for CDC-directly funded CBOs. Numeric Only)	# # # # # # # #
	Session Date	M M D D Y Y Y
	Agency Name	
	Directly Funded CBO Agency ID (For CDC-directly funded CBOs only)	

Which population targeted by your organization's targeted HIV testing program does the client belong to? (primary and secondary target populations will be selected from a drop-down menu specific for each funded agency)

⌐ Primary target population   ⌐ Both target populations
⌐ Secondary target population   ⌐ Not a member of either target population

Is the client at high-risk for HIV infection?	**For HIV-positive clients, only** At the time of this positive test, is the client already in HIV medical care?
⌐ Yes ⌐ No ⌐ Not Assessed	⌐ Yes ⌐ No ⌐ Declined to Answer ☐ Not Asked

Navigation and Prevention and Essential Support Services

Services For HIV Positive Clients Only (Select all that apply)	Referred	Provided	Services For HIV Negative Clients Only (Select all that apply)	Referred	Provided
High Impact Prevention (HIP) behavioral intervention	☐	☐	High Impact Prevention (HIP) behavioral intervention	☐	☐
Medication adherence support services	☐	☐	Non-occupational post-exposure prophylaxis (nPEP)	☐	
Screening for STDs (syphilis, gonorrhea, and chlamydia)	☐	☐	Pre-exposure prophylaxis (PrEP)	☐	
Screening for viral hepatitis	☐	☐	Screening for STDs (syphilis, gonorrhea, and chlamydia)	☐	☐
Screening for TB/TB infection	☐	☐	Screening for viral hepatitis	☐	☐
Treatment for STDs (syphilis, gonorrhea, and chlamydia)	☐		Screening for TB/TB infection	☐	☐
Treatment or vaccination for viral hepatitis	☐		Treatment for STDs (syphilis, gonorrhea, and chlamydia)	☐	
Treatment for TB/TB infection	☐		Treatment or vaccination for viral hepatitis	☐	
			Treatment for TB/TB infection	☐	

Additional Support Services For All Clients (Select all that apply)	Referred
Basic education continuation and completion services	☐
Employment services	☐
Housing services	☐
Insurance navigation and enrollment services	☐
Sex Education, including HIV education (e.g., risk reduction programs, school-based HIV prevention providers)	☐
Mental Health Counseling and Services	☐
Substance abuse treatment and services	☐
Transportation services (to and from HIV prevention and medical care appointments, including HIV medical care appointments)	☐
Primary medical care (*PS17-1704 only*)	☐
Violence prevention services (*PS17-1704 only*)	☐
Education services for hormone replacement therapy (HRT) and sex reassignment procedures (*PS17-1704 only*)	☐
Other: Specify: _____	☐