

INSTRUCTIONS FOR COMPLETION OF THE NEWLY REVISED CDC TEST FORM

The newly revised HIV Test form replaces all prior versions of the form used. Instructions for each section (Part One & Two) of the form are described below. The form should be completed by a health care provider or community health partners administering an HIV test. ***This form should not be completed by the patient.*** Providers will assign a **temporary unique identifier** for their testing clients until the newly revised test forms are distributed. Unique identifiers will be assigned based on health district (i.e., **1-1**) or provider information, client two-digit birth month, client gender (i.e., **01** female & **02** male), and the client's two-digit birth year (**11 02 01 88**).

If a provider completes Test form **Part One** and the patient's HIV test results are confirmed positive, then the provider must complete Test form **Part Two**. You are not required to complete Test form **Part Three**. The provider will keep a copy of the thoroughly completed test form for themselves and send a copy of the form to the State office.

The HIV Test form is designed to collect, in a confidential manner, information that will assist in the identification of newly diagnosed HIV- infected individuals. Accurate and thorough completion of the test forms can provide important information and characteristics (sex, date of birth, race, testing history, and risk factors) that will allow public health to develop and evaluate prevention and care programs targeted at specific at-population s and areas of need.

Please send completed CDC Test forms in a large envelope addressed to:

Georgia Department of Public Health
HIV Unit
2 Peachtree Street, 12th Floor
Attention: Christie Pace 12-224
Atlanta, GA 30303

Test Form Part One.

SITE IDENTIFICATION

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|--|--|---|---|---|---|---|---|---|---|
| Enter or adhere | | | | | | | | | | | | | | | | | |
| Form ID | | | | | | | | | | | | | | | | | |
| Program Announcement (select only one) | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> PS12-1201 Category A | <input type="checkbox"/> PS11-1113 | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> PS12-1201 Category B | <input type="checkbox"/> PS10-1003 | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> PS12-1201 Category C | <input type="checkbox"/> PS08-803 | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> MSM Testing Initiative | | | | | | | | | | | | | | | | |
| Session Date | <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> | | | | | | | | | M | M | D | D | Y | Y | Y | Y |
| | | | | | | | | | | | | | | | | | |
| M | M | D | D | Y | Y | Y | Y | | | | | | | | | | |
| Agency ID Name/Number | | | | | | | | | | | | | | | | | |
| Site ID Name/Number | | | | | | | | | | | | | | | | | |
| Site Type <small>(enter type code from page 2)</small> | F | | | | | | | | | | | | | | | | |
| Site Zip Code | | | | | | | | | | | | | | | | | |
| Site County | | | | | | | | | | | | | | | | | |

FORM ID

- Please provide temporary **FORM ID**. Form ID's are a unique identifier created by provider. Unique ID's are assigned by **Health Districts** (1-1, 1-2, 2-0, 3-1, 3-2, 3-3, 3-4, 3-5,4-0, 5-1, 5-2, 6-0, 7-0, 8-1, 8-2, 9-1, 9-2, 10), **Provider code** (CBO-00, CDC Funded-99, Other-98 (Hospitals, Planned Parenthood, etc.)), **BM** Birth Month (two-digit), **Gender** (Female-01, Male- 02), **BY** Birth Year(two-digit).

DISTRICT CODES

- 1-1 Northwest (Rome)
- 1-2 North Georgia (Dalton)
- 2-0 North (Gainesville)
- 3-1 Cobb-Douglas
- 3-2 Fulton
- 3-3 Clayton (Morrow)
- 3-4 East Metro (Lawrenceville)
- 3-5 DeKalb
- 4-0 LaGrange
- 5-1 South Central (Dublin)
- 5-2 North Central (Macon)
- 6-0 East Central (Augusta)
- 7-0 West Central (Columbus)
- 8-1 South (Valdosta)
- 8-2 Southwest (Albany)
- 9-1 Coastal (Savannah/ Brunswick)
- 9-2 Southeast (Waycross)
- 10-0 (Athens)

SITE CODES

- 00- Community Based Organizations (CBO)
- 99- CDC Funded Programs
- 98- Other (Hospitals, Planned Parenthood etc...)

EXAMPLES OF UNIQUE IDENTIFIERS:

District **BM** **Gender** **BY** = 20060289
20 06 02 89
CBO **BM** **Gender** **BY** = 00070199
00 07 01 99
CDC **BM** **Gender** **BY** = 99110177
99 11 01 77
Other **BM** **Gender** **BY** = 98120277
98 12 02 77

PROGRAM ANNOUNCEMENT

- Select applicable response.

SESSION DATE

- Please make sure to provide session date (mm/dd/yyyy).

AGENCY ID NAME/NUMBER

- Provide required site information (Agency ID, name, type, zip code, and country).

SITE ID NAME/NUMBER

- Provide assigned **SITE ID** (ID used to identify the location where an agency delivers HIV prevention services).

CLIENT INFORMATION

| | | | | | | | | |
|--|--|---|---|--|-------------------------------------|---|---|-----------------------------------|
| Client ID | | | | | | | | |
| Date of Birth | M | M | D | D | Y | Y | Y | |
| (enter 01/01/1800 if unknown) | | | | | | | | |
| Client State | | | | | | | | |
| Client County | | | | | | | | |
| Client Zip Code | | | | | | | | |
| Client Ethnicity | | | | | | | | |
| <input type="checkbox"/> Hispanic or Latino | | | | <input type="checkbox"/> Don't Know | | | | |
| <input type="checkbox"/> Not Hispanic or Latino | | | | <input type="checkbox"/> Declined | | | | |
| Client Race (check all that apply) | | | | | | | | |
| <input type="checkbox"/> American IN/AK Native | | | | <input type="checkbox"/> White | | | | |
| <input type="checkbox"/> Asian | | | | <input type="checkbox"/> Don't Know | | | | |
| <input type="checkbox"/> Black/African American | | | | <input type="checkbox"/> Declined | | | | |
| <input type="checkbox"/> Native HI/Pac. Islander | | | | | | | | |
| Client Assigned Sex at Birth | | | | | | | | |
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | | | | | | | <input type="checkbox"/> Declined |
| Client Current Gender Identity | | | | | | | | |
| <input type="checkbox"/> Male | | | | <input type="checkbox"/> Transgender M2F | | | | |
| <input type="checkbox"/> Female | | | | <input type="checkbox"/> Transgender F2M | | | | |
| <input type="checkbox"/> Declined | | | | <input type="checkbox"/> Transgender unspecified | | | | |
| <input type="checkbox"/> Additional specify: | _____ | | | | | | | |
| Previous HIV Test? | | | | | | | | |
| <input type="checkbox"/> Yes → | If Yes, what is the client's Self Reported Result? | | | | | | | |
| <input type="checkbox"/> No | <input type="checkbox"/> Negative | | | | <input type="checkbox"/> Don't know | | | |
| <input type="checkbox"/> Don't Know | <input type="checkbox"/> Positive | | | | <input type="checkbox"/> Declined | | | |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Preliminary Positive | | | | <input type="checkbox"/> Not Asked | | | |
| <input type="checkbox"/> Not Asked | <input type="checkbox"/> Indeterminate | | | | | | | |

CLIENT ID

- Provide Client ID information.
- **Client ID** is a locally (site) generated unique client ID used to identify an individual client that is receiving HIV Prevention services within a particular agency.

BIRTHDATE

- Enter patient's month, day, and year of birth.
- Enter date in *mmdyyy* format.
- Enter 01/01/1800 if unknown.

CLIENT DEMOGRAPHICS

- Please provide client state, county (**FIPS code**), and zip code information.

ETHNICITY

- Select applicable response.
- If no ethnicity information is available, select "Don't know".
- Please check the appropriate box.

RACE

- Select patient's race even if information is submitted for ethnicity.
- Select more than one race if it is applicable.
- If no race information is provided, select "Don't know".
- Please check the appropriate box.

SEX AT BIRTH

- Ask the patient his/her assigned sex at birth and check the appropriate response.
- If the patient declines a response, please check the box labeled declined.

CURRENT GENDER IDENTITY

- Enter current gender identity of the patient, even if it is the same as the sex assigned at birth male, female, transgender male-to female, transgender female-to-male, transgender unspecified, or additional gender identity.
- For transgender, check appropriate box as communicated by patient regardless of transitional or operative status.

PREVIOUS TESTING INFORMATION

- Ask the client if they have previously taken a HIV test and check the appropriate response.
- If the client says *yes*, ask the client what was their self-reported result and check the appropriate response.

Test Form Part Two.

QUESTION 1.

CDC requires the following information on preliminary & confirmed positives

Was client referred to HIV medical care?

- Yes → If Yes, did client attend the first appointment?
 - Yes → If yes, was the first appointment within 90 days of the HIV test?
 - No
 - Don't Know
 - Yes
 - No
 - Don't Know
 - No
 - Don't Know
- No → If No, why?
 - Client already in HIV medical care
 - Client declined HIV medical care

- Select applicable response.
- If **yes**, please provide additional information

QUESTION 2.

Was client referred to/contacted by Partner Services?

- Yes → If Yes, was the client interviewed for Partner Services?
 - Yes → If yes, was the client interview within 30 days of receiving their result?
 - No
 - Don't Know
 - Yes
 - No
 - Don't Know
 - No
 - Don't Know
- No

- Select applicable response.
- If **yes** to first response, please provide additional information as requested.
- If **yes** to second response, please provide additional information as requested.

QUESTION 3.

Was client referred to HIV Prevention Services?

- Yes → If Yes, did client receive HIV Prevention Services?
 - Yes
 - No
 - Don't Know
- No

- Select applicable response.
- If **yes**, please provide additional information as requested.

QUESTION 4.

If female, is client pregnant ?

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Yes → | If yes, is client in prenatal care? |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Don't Know | <input type="checkbox"/> No |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Not Asked | <input type="checkbox"/> Declined |
| | <input type="checkbox"/> Not Asked |

- Select applicable response.
- If **yes**, please provide additional information as requested.

For Health Departments Use ONLY

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?

- Yes
- No
- Don't Know
- Not Checked

***Instructions for ALL Providers who conduct Counseling and Testing Activities.**

- Please submit a copy of the Georgia HIV Case Reporting Form within 7 days of confirmed HIV diagnosis. Please contact your local health district or the State HIV Surveillance program for assistance with case reporting **1-800-827-9769**.
- The HIV Case Report form can be downloaded from the <http://health.state.ga.us/epi/hivaids> website.