### KENTUCKY HIV TEST FORM

**PART 1**

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<tr>
<th>KY Sticker Number</th>
<th>Session Date</th>
<th>Agency Name</th>
<th>Agency ID Number</th>
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**Client Information**

<table>
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<tr>
<th>Client Birth Year</th>
<th>Client State</th>
<th>Client County</th>
<th>Client Zip Code</th>
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**Client Ethnicity**

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Don’t Know
- [ ] Not Asked

**Client Race**

- [ ] American IN/AK Native
- [ ] Asian
- [ ] Black/African American
- [ ] Native HI/Pac. Islander
- [ ] Other

**Client Gender Assigned at Birth**

- [ ] Male
- [ ] Female
- [ ] Don’t Know
- [ ] Not Asked

**Client Current Gender Identity**

- [ ] Male
- [ ] Female
- [ ] Transgender FTM
- [ ] Transgender MTF
- [ ] Transgender Unspecified
- [ ] Not Asked

**Previous HIV Test?**

- [ ] No
- [ ] Yes
- [ ] Don’t Know
- [ ] Not Asked

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

- [ ] Positive
- [ ] Negative
- [ ] Indeterminate
- [ ] Invalid
- [ ] Don’t Know
- [ ] Not Asked

**Date of Last Test:** ___/___/_____ (MM/YYYY)

**Local Use Fields:**

- L1 (Testing)
  - [ ] 01 General
  - [ ] 03 Targeted (B)
  - [ ] 04 Targeted DIS
  - [ ] 05 CHTC
- L2 (Exposures)
  - [ ] 01 Occupational
  - [ ] 02 Sexual Assault
- L3 (Rapid Tests)
  - [ ] 01 OraQuick
  - [ ] 02 SURE CHECK
  - [ ] 03 INSTI
- L4 (Site Types)
  - [ ] Use codes from p.2 of form instructions

**Sample Date**

<table>
<thead>
<tr>
<th>HIV Test 1</th>
<th>HIV Test 2</th>
<th>HIV Test 3</th>
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<tbody>
<tr>
<td>1 2 3 4</td>
<td>5 6 7 8</td>
<td>9 10 11 12</td>
</tr>
</tbody>
</table>

**Worker Name**

- [ ] Anonymous
- [ ] Confidential
- [ ] Not Hispanic or Latino
- [ ] Hispanic or Latino
- [ ] Don’t Know
- [ ] Declined
- [ ] Yes

**Test Election**

- [ ] Anonymous
- [ ] Confidential
- [ ] Positive/Reactive
- [ ] Indeterminate
- [ ] No Result
- [ ] Venipuncture
- [ ] Rapid

**Test Technology**

- [ ] Venipuncture
- [ ] OraQuick (rapid)
- [ ] SURE CHECK (rapid)
- [ ] Orasure (sent to lab)
- [ ] Positive/Reactive
- [ ] Indeterminate
- [ ] No Result

**Test Result**

- [ ] Positive/Reactive
- [ ] Indeterminate
- [ ] No Result

**Result Provided**

- [ ] No
- [ ] Yes
- [ ] Yes - from another agency

**If Results NOT provided, why?**

- [ ] Declined Notification
- [ ] Did Not Return / Could Not Locate
- [ ] Other

**Choose status of collection of behavioral risk profile:**

- [ ] Client completed behavioral risk profile
- [ ] Client was asked but no risks identified
- [ ] Client was not asked behavioral risk factors
- [ ] Client declined to discuss risk factors

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

- [ ] 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
  - shared drug injection equipment?
- [ ] Vaginal or anal sex with MSM (female only)

**Additional Risk Factors:**

- [ ] Exchange sex for drugs/money/something they need
- [ ] While intoxicated and/or high on drugs
- [ ] With person of unknown HIV status
- [ ] With person who exchanges sex for drugs/money
- [ ] With anonymous partner
- [ ] Diagnosed with a sexually transmitted disease (STD)
- [ ] Sex with multiple partners
- [ ] Oral sex
- [ ] Unprotected vaginal/anal sex with a person who is an IDU
- [ ] Unprotected vaginal/anal sex with a person who is HIV+
- [ ] Unprotected vaginal/anal sex in exchange for drugs/money/or something they need
- [ ] Unprotected vaginal/anal sex with person who exchanges sex for drugs/money
- [ ] Unprotected sex with multiple partners

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**Revised: 10/23/2017 (GCL)**

**Name of HIV Testing Site (optional): ________________**
**PART 2**

Was the client referred to HIV medical care?
- □ No
- □ Client Already in Care
- □ Client Declined Care
- □ Yes
- □ Did the client attend the first appointment?
  - □ Pending
  - □ Confirmed: Accessor Service
  - □ Confirmed: Did Not Access Service
  - □ Lost to Follow-Up
  - □ No Follow-Up
  - □ Don’t Know
- □ Don’t Know
First medical appointment within 90 days of the HIV test?
- □ Yes
- □ No
- □ Don’t Know

Was the client referred to/contacted by Partner Services?
- □ No
- □ Yes
- □ Don’t Know

Was the client interviewed for Partner Services?
- □ No
- □ Yes, within 30 days of receiving their result
- □ Yes, but not within 30 days of receiving their result
- □ Yes, but I don’t know within how many days of receiving their result
- □ Don’t Know

Was the client referred to HIV Prevention Services?
- □ No
- □ Yes
- □ Don’t Know

Did the client receive HIV Prevention Services?
- □ No
- □ Yes
- □ Don’t Know

What was the client’s housing status in the past 12 months? (check all that apply)
- □ Literally Homeless
- □ Unstably Housed and at Risk of Losing Housing
- □ Stably Housed
- □ Not Asked
- □ Declined
- □ Don’t Know

If female, is the client pregnant?
- □ No
- □ Yes
- □ Don’t Know
- □ Declined
- □ Not Asked

Prior to the client testing positive during this test event, was she/he previously reported to the state’s surveillance department as being HIV-positive?
- □ No
- □ Yes
- □ Don’t Know
- □ Not Checked

Date the client reported information
- ________________ (MM/DD/YYYY)

Has the client ever had a previous positive HIV test?
- □ No
- □ Yes
- □ Declined

Date of first positive HIV test: ________________ (MM/DD/YYYY)

Has the client ever had a negative HIV test?
- □ No
- □ Yes
- □ Declined

Date of first negative HIV test: ________________ (MM/DD/YYYY)

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 the client currently using antiretroviral medication (ARV)?
- □ No
- □ Yes
- □ Don’t Know
- □ Declined

Specify ARV medications:
- (use codes on the right)
- # # # # # # #

Date ARV began: ________________ (MM/DD/YYYY)

Date of last ARV use: ________________ (MM/DD/YYYY)

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ARV Medications

22 Agenerase
30 Aptivus
32 Atripla
24 Combivir
38 Complera
06 Crixivan
37 Edurant
11 Emtriva
03 Epivir
28 Epzicom
25 Fortovase
10 Fuzeon
19 Hespera
02 Hivid
23 Hydroxyurea
18 Invirase
34 Intensence
36 Isentress
16 Kaletra
31 Lexiva
07 Norvir
33 Prezista
09 Rescriptor
26 Retrovir
15 Reyataz
08 Saquinavir
35 Selzentry
39 Stribild
21 Sustiva
13 Trizivir
27 Truvada
01 Videx
14 Videx EC
17 Viracept
05 Viramune
12 Viread
04 Zerit
20 Ziagen
88 Other
99 Unspecified

Revised: 10/23/2017 (GCL)
General Instructions

1. Use a blue or black ink pen to complete this form.
2. Please print your responses legibly. Unclear and incomplete forms will be sent back to your agency to be fixed.
3. Multiple choice boxes (□) should be clearly marked with a “X” only.
4. Part one of the HIV test form should be completed for everyone who receives a HIV test. Part two of the HIV test form should be completed for everyone confirmed HIV-positive (by Kentucky Division of Laboratory Services, Western Blot, IFA or “Rapid-Rapid” protocol).
5. There are no preprinted Form ID or Client ID numbers. You must adhere or write in the form identification (KY Sticker) number on Part one and, when applicable, Part two of the HIV test form. Do not create your own sticker numbers—these must be obtained from the state HIV/AIDS Branch.
6. To order more KY numbered stickers, call or e-mail Kay.Loftus@ky.gov
7. Mail* completed forms for the current month by the 15th of the following month** to:
   
   CHFS - HIV/AIDS Branch
   
   Attn: Kay Loftus
   
   275 E. Main St., HS2E-C
   
   Frankfort, KY 40621-0001

   *Agencies completing direct data entry (DDE) into the EvaluationWeb online system should enter data into the system by the 15th of the following month. Forms entered in this fashion should not be mailed to the HIV/AIDS Branch. Instead, keep your entered test forms for one year from the date of the test or in accordance to your agency’s record retention policies, whichever time frame is longer. Records ready for expunging should follow HIPAA guidelines for disposal.

   **The exception to this rule is if you have a confirmed HIV-positive client, it may take up to 90 days to complete part two of the HIV test form. Part one and part two must be completed and sent in together.

   **Newly infected HIV cases, confirmed by Kentucky Division of Laboratory Services, Western Blot, IFA or “Rapid-Rapid” protocol, are to be reported to HIV Surveillance within 5 business days. Reactive results on a Rapid Test are not reportable until they have been confirmed. (see p.3 for more info)

   9. Blank HIV test forms and HIV reportable disease forms can be obtained at http://chfs.ky.gov/forms

   10. If you have questions or general concerns, please contact us at 800-420-7431

HIV Test Form – Part One

Left-side column:

1. KY Sticker Number
   
   Use KY Sticker as the Form ID

2. Session Date
   
   Date of the HIV test

3. Agency Name
   
   Write out your agency name

4. Agency ID Number
   
   Use your assigned agency number

5. Client’s Birth Year
   
   Four digit number. If unknown, enter 1800.

6. Client’s State
   
   The state in which the client resides (see p.3)

7. Client’s County
   
   The county in which the client resides

8. Client’s Zip Code
   
   The zip code in which the client resides

9. Client Ethnicity
   
   Choose one

10. Client Race
    
    Choose all that apply

11. Client Assigned Sex at Birth
    
    Choose one

12. Client Current Gender Identity
    
    Choose one or enter additional identity

13. Previous HIV Test
    
    Choose one; if “yes,” indicate previous result and date of last test (if known)

14. Local Use Fields
    
    For fields L1 – L3, choose one
    For field L4, use codes from p.2

Right-side column:

1. Sample Date
   
   Date of the HIV test

2. Worker Name
   
   Enter first name and last initial of the tester

3. Test Election
   
   Choose one

4. Test Technology
   
   Choose one

5. Test Result
   
   Choose one

6. Result Provided
   
   Choose one

7. If result not provided, why?
   
   If applicable, choose one

8. Choose One [Risk Profile]
    
    Choose one

9. Table [Client Identified Risks]
    
    Choose all that apply

10. Additional Risk Factors
    
    Choose all that apply

11. Name of HIV Testing Site
    
    Optional, enter where test took place

Two “Rapid-Rapid” Protocols are Available:

1. Begin with INSTI, follow up positives with SURE CHECK or OraQuick

2. Begin with SURE CHECK, follow up positives with OraQuick
HIV Test Form – Part Two

1. KY Sticker Number
   Use a second KY Sticker (duplicate) that corresponds to HIV Test Form Part One to link these two pages

2. Was the client referred to HIV medical care?
   Choose one
   If “no,” why was the client not referred into care?
   Choose one; move on to the next question
   If “yes,” did the client attend the first appointment?
   Choose one; move on to the next question if “confirmed – accessed service” was not chosen
   If “confirmed – accessed service,” did the client attend the appointment within 90 days?
   Choose one; move on to the next question

3. Was the client referred to Partner Services?
   Choose one
   If “yes,” was the client interviewed for partner services?
   Choose one; move on to the next question

4. Was the client referred to HIV Prevention Services?
   Choose one
   If “yes,” did the client receive HIV Prevention Services?
   Choose one; move on to the next question

5. What was the client’s housing status in the past 12 months?
   Check all that apply

6. If female, is the client pregnant?
   Choose one
   If “yes,” is the client in prenatal care?
   Choose one; move on to the next question

7. Prior to the client testing positive during this testing event, was he/she previously reported to the jurisdiction’s HIV Surveillance Department as being HIV-positive?
   Choose one; move on to the next question

8. Date client reported information for Part Two of HIV Test Form
   Enter the date you asked the client the questions on Part Two of the HIV Test Form

9. Has the client ever had a previous positive HIV test?
   Choose one
   If “yes,” enter a date.
   Enter the date of the client’s last previously positive HIV test

10. Has the client ever had a previous negative HIV test?
    Choose one
    If “yes,” enter a date.
    Enter the date of the client’s last previously negative HIV test

11. How many negative HIV tests did the client have within 24 months before current (or first positive) HIV test?
    Enter number of tests, if known, or choose “Don’t Know” or “Declined”

12. Has client used or is client currently using antiretroviral medication (ARV)?
    Choose one
    If “yes,” list current medications.
    Choose medication codes from the right side of the page
    If “yes,” enter a date when ARV began and date of last ARV use.
    Enter the dates according to what the client reports
    This form is now complete

Additional Risk Factor Codes

01 Exchange sex for drugs/money/or something they needed
02 While intoxicated and/or high on drugs
05 With person of unknown HIV status
06 With person who exchanges sex for drugs/money
08 With anonymous partner
12 Diagnosed with a sexually transmitted disease (STD)
13 Sex with multiple partners
14 Oral sex

Local Use Field L4 (Testing Site Types)

01 Inpatient Hospital 07 Pharmacy/Retail Clinic 12 HIV Testing Site 18 Public Area
02 TB Clinic 08 STD Clinic 13 School/Education Facility 19 Individual Residence
03 Substance Abuse Facility 09 Dental Clinic 14 Church/Religious Facility 20 Other Non-Clinical
04 Community Health Center 10 Correctional Facility 15 Shelter Facility 21 HD – Field Visit
05 Emergency Department 11 Other Clinic 16 Commercial Facility
06 Primary Care Clinic
State and U.S. Territory Abbreviations

<table>
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<th>State or U.S. Territory</th>
<th>Abbreviation</th>
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Site IDs and Names

If you need to know your Site ID number, you may contact the HIV/AIDS Branch at 800-420-7431.

Disease Reporting to HIV/AIDS Surveillance Branch

1. Report either by phone or mail; do not fax any confidential information
2. When mailing, please place case forms inside of two (2) sealed envelopes, both marked “CONFIDENTIAL”
3. Adult and Adolescents Reporting Form is for ages ≥13, the Pediatrics Reporting Form is for ages <13
4. Blank forms can be obtained by visiting http://chfs.ky.gov/forms

Reports from Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer and Trimble Counties:

- Phone: Nichelle Anderson at 502-574-6574
- Mail: Louisville Metro Health Department
  Attn: Nichelle Anderson
  400 East Gray St., Rm 317
  Louisville, KY 40202

Reports from all other 113 Kentucky Counties:

- Phone: Julie Nakayima or Julie Kauzlarich at 866-510-0008 or 502-564-0536
- Mail: Kentucky Department for Public Health
  Attn: Julie Nakayima
  275 E. Main Street, HS2E-C
  Frankfort, KY 40621

Additional information on the state regulation regarding reporting is available at http://chfs.ky.gov/dph/epi/hivaims.htm