HIV/AIDS Disease Information System

Counseling and Testing Form

Annual Refresher Training
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Instructions</td>
<td>5</td>
</tr>
<tr>
<td>Patient Information</td>
<td>5</td>
</tr>
<tr>
<td>Test Technology</td>
<td>6</td>
</tr>
<tr>
<td>Final Interpretation</td>
<td>6</td>
</tr>
<tr>
<td>Pre-Test Information</td>
<td>7</td>
</tr>
<tr>
<td>Client Risk Factors</td>
<td>7</td>
</tr>
<tr>
<td>Post-Test Notification</td>
<td>8</td>
</tr>
<tr>
<td>Referrals</td>
<td>8</td>
</tr>
<tr>
<td>Antiretroviral Therapy</td>
<td>8</td>
</tr>
</tbody>
</table>

## APPENDIX

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Sex Codes</td>
<td>9</td>
</tr>
<tr>
<td>Gender Codes</td>
<td>9</td>
</tr>
<tr>
<td>Ethnicity Codes</td>
<td>9</td>
</tr>
<tr>
<td>Race Codes</td>
<td>9</td>
</tr>
<tr>
<td>Housing Status Codes</td>
<td>9</td>
</tr>
<tr>
<td>Site Codes</td>
<td>9</td>
</tr>
<tr>
<td>County Codes</td>
<td>10</td>
</tr>
<tr>
<td>Instructions for submitting form</td>
<td>10</td>
</tr>
</tbody>
</table>

## ATTACHMENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT-109 Form`</td>
<td>11</td>
</tr>
<tr>
<td>Security Portal</td>
<td>12</td>
</tr>
<tr>
<td>Counseling and Testing Form</td>
<td>12</td>
</tr>
<tr>
<td>Lookup Form</td>
<td>13</td>
</tr>
<tr>
<td>Patient Information</td>
<td>13</td>
</tr>
<tr>
<td>Provider Information</td>
<td>14</td>
</tr>
<tr>
<td>Pre-Test Information</td>
<td>14</td>
</tr>
<tr>
<td>Manually-Entered Test Data</td>
<td>14</td>
</tr>
<tr>
<td>Post-Test Information</td>
<td>14</td>
</tr>
<tr>
<td>Search for CTS Forms</td>
<td>15</td>
</tr>
<tr>
<td>Search for Patient</td>
<td>15</td>
</tr>
<tr>
<td>Condom Distribution Form</td>
<td>16</td>
</tr>
<tr>
<td>HADIS Pr Form (ERTS)</td>
<td>16</td>
</tr>
</tbody>
</table>
INTRODUCTION

HADIS is the Alabama Department of Public Health (ADPH), HIV/AIDS Division’s test form. The HIV Ag/Ab Serology Lab Form version 4.4 (ADPH-CL-109) was revised on April 4, 2015. These instructions were revised on July 1, 2016.

HADIS provides internet access to multiple HIV/AIDS Division forms and reports; including Counseling and Testing (CTS), Condom distribution and use, and the Patient Re-engagement Form (PrForm).

Access to HADIS (and other state programs) requires using the ADPH Security Portal https://dph.state.al.us/adphsec/(S(rqembe55ulhgru553regvp45))/Login.aspx. Select: Create an account. Specific access and rights to HADIS are controlled by the HIV/AIDS Division Data Management Director (DMD). Access is strictly limited to HIV/AIDS medical care providers funded for CTS testing under Federal Grant.
**State Employees**

Are you a State employee in either ADPH or Medicaid?
\[ \checkmark \text{No} \quad \checkmark \text{Yes} \]

<table>
<thead>
<tr>
<th>Username/Password</th>
<th>Minimum Password Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>username</strong></td>
<td>• Minimum 6 characters in length</td>
</tr>
<tr>
<td><strong>password</strong></td>
<td>• Maximum 20 characters in length</td>
</tr>
<tr>
<td></td>
<td>• Passwords may contain the following:</td>
</tr>
<tr>
<td></td>
<td>- Uppercase Letters</td>
</tr>
<tr>
<td></td>
<td>- Lowercase Letters</td>
</tr>
<tr>
<td></td>
<td>- Numbers</td>
</tr>
<tr>
<td></td>
<td>- Spaces are not allowed</td>
</tr>
<tr>
<td></td>
<td>- Symbols _ $ @ # -</td>
</tr>
</tbody>
</table>

Choose a username and a password below. Your username must be at least 3 and may be no more than 20 characters in length. The password requirements are listed to the right.

Please confirm your password
INSTRUCTIONS FOR COMPLETING THE HIVAg/Ab SEROLOGY LAB FORM 4.6
(ADPH-CL-109) Revised 04/04/2015

The form must be completed as instructed to assure accurate information is collected. When completing the form by hand, please print legibly. Check the square or circle to indicate responses. Use a ball point pen to complete the form, please press firmly to ensure that the all marks come through on all copies of the form.

Please note the following:
The HIVAg/Ab Serology Lab Form 4.6 (ADPH-CL-109) is to be completed on each individual who, following pretest counseling and signed consent is tested for HIV antigens and antibodies. All clients must have provided consent as documented by your agency policy for HIV testing. All clients have the right to “opt out” of HIV testing.

PATIENT INFORMATION

If completing Patient/Provider information by hand, complete as follows: (numbers on form correspond to numbered instructions)
1. Patient’s Last Name
2. Patient’s First Name
3. Patient’s middle initial
4. Date of Birth (Month, day, year – xx/xx/xxxx)
5. CHR # (Skip)
6. Patient’s Birth Sex
7. Patient’s Current Gender
8. Patient’s 9 digit Social Security Number (If no SSN, leave the field blank.)
9. Date Specimen Collected (month, day, year)
10. Ethnicity (Choose only one.)
11. Race (Check all that apply.)
12. Patient’s Address
13. Patient’s County Code
14. Patient’s Apartment Number
15. Patient’s City
16. Patient’s State
17. Patient’s Zip Code
18. Patient’s Telephone Number
19. Housing Status
20. Provider Name
21. Provider Site Code
22. Provider County
23. Provider Zip Code
24. Provider Address
25. Provider City (Do not use abbreviations. Complete on all four copies of the form.)
Enter the Site Code and County Code even if using a label or stamped address such as PHALCON

**Test Technology**
*Skip this section unless entering Rapid screening and/or Confirmatory test information acquired from a laboratory other than the State Lab.

26. *Check the square that corresponds to the test technology.
27. *Check the square that corresponds to the specimen type.
28. *Date Received
29. *Date Reported
30. *Check the appropriate (EIA) test result.

- *EIA HIV Ag/Ab (GS HIV Ag/Ab Combo EIA)
  - Nonreactive
  - Reactive
  - Unsatisfactory

- *HIV-1 EIA Differentiation (HIV-1/2 Multispot Immunoassay/Geenius)
  - HIV-1 Nonreactive
  - HIV-1 Reactive
  - HIV-1 Unsatisfactory
  - HIV-1 Indeterminate

- *HIV-2 EIA Differentiation
  - HIV-2 Nonreactive
  - HIV-2 Reactive
  - HIV-2 Unsatisfactory
  - HIV-2 Indeterminate

- *HIV-1 NAAT/RNA assay (HIV-1 RNA Qualitative Assay)
  - RNA Nonreactive
  - RNA Reactive
  - RNA Unsatisfactory

**Final Interpretation:**

i.e. Positive for HIV-1 antibodies. Laboratory evidence consistent with established HIV-1 infection is present

i.e. Negative for HIV-1 antigen and HIV ½ antibodies. No laboratory evidence of HIV infection. If acute HIV infection is suspected, consider testing for HIV-1 RNA.

i.e. HIV-1 RNA was not detected. HIV-1/2 Multispot was Nonreactive. HIV antibodies were not confirmed and HIV-1 RNA was not detected. No laboratory evidence of HIV-1 infection. Follow-up testing for HIV-2 should be performed if clinically indicated.
Pre-Test Information
This information should be filled in to the best of the client’s memory. If they are unable to remember the exact day, month, and year, please complete as much as they can remember.

31. Check the circle that corresponds with previous HIV test results. If client answered “No, Don’t Know, Declined or Not Asked” about a previous test, skip Steps 33-37. Do not count today’s test in this section.
32. Check the circle that corresponds with self reported results. (If Positive, Preliminary Positive or Indeterminate, go to Steps 33-34, skip Step 35, and indicate 0 in Step 36. If Negative, go to Step 35).
33. If the client answered “yes” to a previous HIV test, indicate the state.
34. Indicate the day, month and year of the first positive HIV test.
35. Indicate the day, month, and year of the last negative HIV test.
36. Indicate the number of negative HIV tests within the last 12 months.

Client Risk Factors

37. Check the client risk factors. Choose only one.
38. If risk factors were discussed, indicate (1) if a Risk Reduction plan was developed, and (2) with whom the client had vaginal or anal sex in the past 12 months:

- Check the appropriate circle/s to select the risk factor/s for each of the three genders (male, female, and transgender), including condom use.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Risk Factor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Male Intravenous Drug User (IDU)</td>
<td>HIV + male</td>
</tr>
<tr>
<td>Female</td>
<td>Female IDU</td>
<td>HIV+ female</td>
</tr>
<tr>
<td>Transgender</td>
<td>Transgender IDU</td>
<td>HIV+ transgender</td>
</tr>
</tbody>
</table>

39. Indicate if a female client had sex with a man who has sex with men (MSM).
40. Check the circle if the client used injection drugs and if drug equipment was shared.
41. Check additional risk factors that apply to the client.

- oral sex
- sex with multiple partners
- sex with a person who had an STD
- sex while intoxicated or high
- sex with a person of unknown risk
- sex with an anonymous partner
- sex in exchange for drugs, money or something they needed
- sex with someone who exchanges sex for drugs, money, or something they need
- sex with someone who has hemophilia, or had a transfusion or transplant

42. Check the circle if the client elected to be tested. (if the client chooses not to be tested, stop now and destroy the form)
43. Indicate the agency worker collecting pre-test information (Last Name, First Name).
**Post Test Notification**

44. Indicate if test results were provided.
45. If test results were not provided blacken the circle that indicates the reason. (If the client has not returned after 30 days for their results, indicate Did Not Return.)
46. Indicate the date test results were given to the client.

**Referrals for HIV+ Clients Only: Centers for Disease Control Required Data**
(Referral of HIV Positive clients for Medical, PCRS, and Prevention Services are required as part of the policy and procedures for agencies receiving federal grants. All HIV Positive clients, either previously infected or newly infected should be referred for care and services.)

47. Indicate if the client was referred to medical care.
48. If the client was not referred to medical care, indicate why.
   Indicate if the client was referred to medical care and attended the appointment.
   (The HIV/AIDS Division will follow-up to determine if the client attended the medical care appointment.)
49. Indicate if the client was referred to the health department’s Disease Intervention Specialist (DIS) for Partner Services. (HIV/AIDS Division will determine if the client was interviewed for Partner Services.)
50. Indicate if the client was referred to HIV Prevention Services. (HIV Prevention Services can be provided by the testing provider or another provider. Referral services include testing for STD’s and TB.)
   If “yes” indicate if the client received the services
51. Indicate if the client is pregnant.
   If “yes” indicate if the client is receiving prenatal care. (If not, the client should be referred for prenatal care.)

**Antiretroviral Therapy**

52. Indicate if the client has been prescribed and is taking antiretroviral therapy.
   If “yes” indicate what the client is taking.
53. If the client is taking antiretrovirals (ART), list the date the ART was first and last taken.
54. Indicate the agency worker collecting post-test information (Last Name, First Name).
APPENDICES

BIRTH SEX CODES
01 - Male
02 - Female
03 - Declined

GENDER CODES
01 - Male
02 - Female
03 - Declined
04 - Transgender (Male to Female)
05 - Transgender (Female to Male)
06 - Transgender (Unspecified)
07 - Declined

ETHNICITY CODES
01 - Hispanic
02 - Not Hispanic/Latino
03 - Don’t Know
04 - Declined

RACE CODES (Multiple races are allowed)
01 - American Indian/Alaska Native
02 - Asian
03 - Black/African American
04 - White
05 - Native Hawaiian/Pacific Islander
06 - Don’t Know
07 - Declined

HOUSING STATUS CODES
1 - Literally Homeless
2 - Imminently Losing Housing
3 - Unstably Housed and At-Risk of Losing Housing
4 - Stably Housed
5 - Don’t Know
6 - Declined
7 - Not Asked

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 provider.)

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 - Lauderdale  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
16 - Coffee  33 - Hale  49 - Mobile  66 - Wilcox
17 - Colbert  34 - Hale  50 - Monroe  67 – Winston

Instructions for submitting the HIV Serology Form to the Division of HIV/AIDS Prevention & Control

Please submit serology information on positive and negative test results in the following format. After the client has been post-test counseled the **Control Copy** will be completed and sent to the HIV/AIDS Division. **(Do not keep for more than 30 days)** The Provider Copy (Pg. 4) should be placed in the client’s record. The remaining copies may be shredded. The **CONTROL COPY** will be forwarded to the attention of Gail Johnson or Tamara Foster, Suite 1400, 201 Monroe Street, Montgomery, AL., 36104.
HIV Counseling & Testing

**Alabama Department of Public Health**

**Form:** 1571002

### Patient Information

1. **Patient's Last Name:** [ ]
2. **Patient's First Name:** [ ]
3. **DOB:** [ ]
4. **Social Security Number:** [ ]
5. **Date Specimen Collected:** [ ]

#### Patient Address

- [ ] Male
- [ ] Female
- [ ] Declined

#### Patient City

#### Patient County

#### Patient Zip Code

#### Patient Phone Number

#### Provider Name

#### Provider City

#### Provider Address

#### Provider County

#### Provider Zip Code

### Confirmatory Diagnostic Results

**Specimen Type:** [ ]
- Blood
- Tissue

**Date Reported:** [ ]

**Result:**
- HIV-1 NTRNA assay
- HIV-2 NTRNA assay
- RNA Nonreactive
- RNA Reactive

### Pre-Test Information

#### Previous HIV Test:
- Positive
- Negative
- Don't know
- Declined
- Not Asked

#### Test Technology:
- Conventional
- NA/RT
- Other

#### Date Received:

**Result Provided:**
- [ ] Yes
- [ ] No

**CDC Requires the Following Information On Positive:**
- [ ] Yes
- [ ] No

### Client Risk Factors

#### Client Refused to Discuss Risk Factors
- [ ] Yes
- [ ] No

#### Client Refused to Discuss Risk Factors
- [ ] Yes
- [ ] No

### Client Risk Factors Were Discussed, Have Client Answer the Following for the Past 12 Months:

- [ ] Vaginal or Anal Sex
- [ ] Client shared a condom?
- [ ] Yes
- [ ] No

#### If a Female, Did Client Have Sex with a MENT?
- [ ] Yes
- [ ] No

#### Has Client Used Injection Drugs?
- [ ] Yes
- [ ] No

#### Choose any additional risk factors that apply:
- [ ] Sex with multiple partners
- [ ] Sex with person who had an STD
- [ ] Sex with a person of unknown risk
- [ ] Sex with a person with an anonymous partner
- [ ] Sex in exchange for drugs, money, or something they need
- [ ] Sex with someone who exchanges sex for drugs, money, or something they need
- [ ] Sex with someone who has hemophilia or has a transfusion or transplant

#### Did Client Refuse to Be Issued?
- [ ] Yes
- [ ] No

#### Worker Collection Pre-Test Information
- [ ] Last Name
- [ ] First Name

For HIV/AIDS Central Office Use Only

Previously Reported in Surveillance System?
- [ ] Yes
- [ ] No
- [ ] Not checked

STATENO

LAB TESTING AGENCY

POST-TEST NOTIFICATION

**Result Provided:**
- [ ] Yes
- [ ] No

**CDC Requires the Following Information On Positive:**
- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Client Risk Factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. If client tested positive, did client have sex with a MENT?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Q2. Has client used injection drugs?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Q3. Choose any additional risk factors that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4. If a female, did client have sex with a MENT?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Q5. Worker collection Pre-Test Information:</td>
<td>Last Name</td>
<td>First Name</td>
</tr>
</tbody>
</table>

Data Post-Test Completed: [ ]

**Sub** Worker collection Pre-Test Information: | [ ] Last Name | [ ] First Name |
HADIS SCREEN SHOTS

ADPH SECURITY PORTAL
https://dph.state.al.us/adphsec/Login.aspx
HADIS APPLICATION

Portal Login

HADIS-Counseling and Testing Form

HIV/AIDS Disease Information System

Counseling and Testing Form
Use this form to enter HIV Counseling and Testing data.
### Lookup Form

Counseling and Testing Form

Use this form to enter HIV Counseling and Testing data.

#### Look up Existing Form for Editing

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Surveillance Case Number (STATENO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Comprehensive Health Record</th>
<th>Birth Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Gender</th>
<th>Select an Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date Specimen Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Select options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Select an Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Phone Number</th>
<th>Housing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Select an Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Provider Information

Pre-Test Information

Manually-Entered Test Data

Post-Test Information

Antiretroviral Drugs
Search for Counseling and Testing Forms

Search for Counseling and Testing Forms

<table>
<thead>
<tr>
<th>Form Number:</th>
<th>Case Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accession Number:</th>
<th>First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Search

Search for Patients

Search for Patients

<table>
<thead>
<tr>
<th>Case Number:</th>
<th>First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Social Security Number: | |
|-------------------------||
|                         | |

Search
HADIS-Condom Distribution

HADIS-PR Form

Patient Re-Engagement Form

Patient Re-Engagement Forms

Enter PR Form Details

Save