##

OMB # 0920-0696 Exp. Date:08/31/2010

Pacific Islands HIV Test Form

Worker ID

Session Date	Jurisdiction	Site Type ID	Client ID	Client Date of Birth
m m d d y y				m m d d y y y y

Current Residence

Island (Specify) _____

Village (Specify) _____

FSM ❑ Yap State ❑ Chuuk State ❑ Kosrae State ❑ Pohnpei State

Other (Specify) _____

Gender

❑ Male
❑ Female
❑ Transgender – M to F
❑ Transgender – F to M

Ethnicity

❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Don't know

Race

Check all that apply

❑ American Ind/AK Native
❑ Asian
❑ Black/African American
❑ Native HI/Pac. Islander
❑ White
❑ Don't know

Specify nationality _____

Client Risk Factors

1. In the past 12 months, have you had sex with a male (vaginal or anal)?
   ❑ Yes---------- No. of partners
   ❑ No
   … with a female (vaginal or anal)?
   ❑ Yes---------- No. of partners
   ❑ No

2. Have you had sex in the past 12 months (vaginal or anal):
   a – Without using a condom? ❑ Yes ❑ No
   b – With person who is HIV positive? ❑ Yes ❑ No
   c – In exchange for drugs, money, or gifts? ❑ Yes ❑ No
   d – While using alcohol? ❑ Yes ❑ No
   e – While using drugs? ❑ Yes ❑ No

3. In the past 12 months, have you injected any drugs? ❑ Yes ❑ No

4. In the past 12 months, did you engage in any other behaviors or activities that you feel increased your risk for HIV? ❑ Yes ❑ No
   If yes, specify:
   _____
   _____

5. In the past 12 months, have you been diagnosed with any of the following STDs (not HIV)?
   Chlamydia ❑ Yes ❑ No
   Gonorrhea ❑ Yes ❑ No
   Syphilis ❑ Yes ❑ No
   Other ❑ Yes ❑ No

Previous HIV Test?

❑ Yes ---------- *If yes, date of last test* m m y y
❑ No
❑ Don't know
❑ Declined
❑ Not Asked

Self-reported Previous HIV Test Result

❑ Positive
❑ Negative
❑ Preliminary positive
❑ Indeterminate
❑ Don't know
❑ Declined
❑ Not asked

For clients who tested HIV positive

Was client given a TB test? ❑ Yes ❑ No

Was client referred to HIV prevention services? ❑ Yes ❑ No

Was client referred to medical care? ❑ Yes ❑ No

If female, is client pregnant? ❑ Yes ❑ No

If yes:

Is client in prenatal care? ❑ Yes ❑ No

Was client referred to Partner Counseling and Referral Services (PCRS)? ❑ Yes ❑ No

	HIV Test 1	HIV Test 2
Test ID number		
Sample date	m m d d y y	m m d d y y
Test election:	❑ Tested anonymously ❑ Tested confidentially ❑ Declined testing	❑ Tested anonymously ❑ Tested confidentially ❑ Declined testing
Test technology:	❑ Conventional ❑ Rapid	❑ Conventional ❑ Rapid
Specimen type:	❑ Blood: finger stick ❑ Blood: venipuncture ❑ Blood spot ❑ Oral mucosal transudate ❑ Urine	❑ Blood: finger stick ❑ Blood: venipuncture ❑ Blood spot ❑ Oral mucosal transudate ❑ Urine
Test result:	❑ Positive/reactive ❑ Invalid ❑ Negative ❑ No result ❑ Indeterminate	❑ Positive/reactive ❑ Invalid ❑ Negative ❑ No result ❑ Indeterminate
Result provided?	❑ Yes ❑ No	❑ Yes ❑ No
Date provided:	m m d d y y	m m d d y y
If results not provided, why not?	❑ Declined notification ❑ Did not return/Could not locate ❑ Obtained results from another agency	❑ Declined notification ❑ Did not return/Could not locate ❑ Obtained results from another agency

Local Use Fields

L1				
L2				
L3				
L4				
L5				
L6				