Ohio EvaluationWeb 2019 HIV Test Template

Instructions

Within each numbered section, move from top to bottom of column A (on the left), then from top to bottom of column B (on the right).

There are three different response formats that you will use to record data: text boxes (used to write in information like codes and dates), and check boxes.

Six data fields are mandatory for a valid testing event:

- Form ID (write in or adhere a sticker with the Form ID number to each data entry page)
- Session Date
- Program Announcement
- Jurisdiction (populated automatically in EvaluationWeb)
- Agency ID (populated automatically in EvaluationWeb)
- Site ID (populated automatically in EvaluationWeb)

Write in the name of the Agency and Site number on all Opscan forms.

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 recipients are encouraged to include the CDC Assurance of Confidentiality 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 Service Act, 42 USC 242b and 242k. Your cooperation is necessary for the 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 NHMNE 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 Confidentiality 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)).

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☐ Referred by DIS for Testing

☐ Opscan Form with Corrections

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere)*

If client tests positive for HIV:
ODRS ID (if applicable) _____
Client Name _____
Client Contact Information

1 | Agency and Client Information *(complete for all persons)*

Session Date

Program Announcement ☒ *PS18-1802*

Agency Name

Site ID Number

Site Zip Code

Site County

Local Client ID *(optional)*

Test Counselor ID

Client Date of Birth *(1/1/1800 if unknown)*

Client State *(USPS abbreviation)*

Client County

Client Zip

Client Ethnicity
☐ Hispanic or Latinx ☐ Don't Know
☐ Not Hispanic or Latinx ☐ Declined to Answer

Client Race
☐ American Indian/Alaska Native ☐ White
☐ Asian ☐ Not Specified
☐ Black or African American ☐ Declined to Answer
☐ Native Hawaiian or Pacific Islander ☐ Don't Know

Client Assigned Sex at Birth
☐ Male ☐ Female ☐ Declined to Answer

Client Current Gender Identity
☐ Male ☐ Transgender Unspecified
☐ Female ☐ Another Gender
☐ Transgender Male to Female ☐ Declined to Answer
☐ Transgender Female to Male

Has the client ever previously been tested for HIV?
☐ No ☐ Yes ☐ Don't Know

2 | PrEP Awareness and Use *(complete for all persons)*

Has the client ever heard of PrEP?
☐ No ☐ Yes

Is the client currently taking daily PrEP medication?
☐ No ☐ Yes

Has the client used PrEP anytime in the last 12 months?
☐ No ☐ Yes

3 | Priority Populations *(complete for all persons)*

In the past five years, has the client had sex with a male?
☐ No ☐ Yes

In the past five years, has the client had sex with a female?
☐ No ☐ Yes

In the past five years, has the client had sex with a transgender person?
☐ No ☐ Yes

In the past five years, has the client injected drugs or other substances?
☐ No ☐ Yes

4 | Final Test Information *(complete for all persons)*

Test Type *(select one only)*

☐ CLIA-waived Point of care (POC) Rapid Test(s)

POC Rapid Test Result
☐ Preliminary Positive
☐ Verified Positive
☐ Negative
☐ Discordant
☐ Invalid

☐ Laboratory-based Test(s)

Lab-based Test Result
☐ HIV-1 Positive
☐ HIV-1 Positive, possible acute
☐ HIV-2 Positive
☐ HIV Positive, undifferentiated
☐ HIV-1 Negative, HIV-2 Inconclusive
☐ HIV-1 Negative
☐ HIV Negative
☐ Inconclusive, further testing needed

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Form ID (*enter or adhere)*

ODRS ID *(if applicable)* _____

4 | Final Test Information (cont)
(complete for all persons)

HIV Test Election
☐ Anonymous ☐ Confidential ☐ Test Not Done

HIV Test Result Provided to Client?
☐ No ☐ Yes ☐ Yes, client obtained the result from another agency

5 | Additional Tests
(complete for all persons)

Was the client tested for co-infection?
☐ No ☐ Yes

Tested for Syphilis?
☐ No ☐ Yes

Syphilis Test Result
☐ Newly Identified Infection
☐ Not Infected
☐ Not Known

Tested for Gonorrhea?
☐ No ☐ Yes

Gonorrhea Test Result
☐ Positive ☐ Negative
☐ Not Known

Tested for Chlamydial infection?
☐ No ☐ Yes

Chlamydial Infection Test Result
☐ Positive ☐ Negative
☐ Not Known

Tested for Hepatitis C?
☐ No ☐ Yes

Hepatitis C Test Result
☐ Positive ☐ Negative
☐ Not Known

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

6 | Risk Assessment *(complete for persons testing negative)*

Is the client at risk for HIV infection?
☐ No ☐ Yes ☐ Risk Not Known ☐ Not Assessed

7 | PrEP Eligibility and Referral *(complete for persons testing negative)*

Was the client screened for PrEP eligibility?
☐ No ☐ Yes

Is the client eligible for PrEP referral?*
☐ No ☐ Yes

Was the client given a referral to a PrEP provider?
☐ No ☐ Yes

Was the client provided navigation or linkage services to assist with linkage to a PrEP provider?
☐ No ☐ Yes

If the client was not given a referral to a PrEP Navigator or PrEP provider, please explain why:
☐ Client declined ☐ Referral not offered ☐ Services not available
☐ Other: _____

8 | Essential Support Services *(complete for persons testing negative)*

	Screened for need	Need determined	Provided or referred
Health Benefits navigation and enrollment	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Evidence-based risk reduction intervention	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Behavioral health services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Social services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Notes *(optional)*

_____
_____

*All clients who test negative for HIV are eligible for PrEP.

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere)*

ODRS ID *(if applicable)* _____

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

9 | Positive Test Result *(complete for persons testing positive)*

Did the client attend an HIV medical care appointment after this positive test?
- ☐ Yes, Confirmed
- ☐ Yes, client/patient self-report
- ☐ No
- ☐ Don't Know

→ Date attended

Rapid Linkage
- ☐ Same day medical visit
- ☐ Same day referral

Agency/Facility	
Provider Name	

Has the client ever had a positive HIV test prior to this event?
- ☐ No
- ☐ Yes
- ☐ Don't Know

→ Date of first positive HIV test

Was the client provided with individualized behavioral risk-reduction counseling?
- ☐ No
- ☐ Yes

Was the client's contact information provided to the health department for Partner Services?
- ☐ No
- ☐ Yes

Client's most unstable housing status in last 12 months?
- ☐ Literally Homeless
- ☐ Unstably Housed or at Risk of Losing Housing
- ☐ Stably Housed
- ☐ Not Asked
- ☐ Declined to Answer
- ☐ Don't Know

If the client is female, is she pregnant?
- ☐ No
- ☐ Yes
- ☐ Declined to Answer
- ☐ Don't Know

→ Is the client in prenatal care?
- ☐ No
- ☐ Not Asked
- ☐ Declined to Answer
- ☐ Yes
- ☐ Don't Know

→ Was the client screened for need of perinatal HIV service coordination?
- ☐ No
- ☐ Yes

→ Does the client need perinatal HIV service coordination?
- ☐ No
- ☐ Yes

→ Was the client referred to perinatal HIV service coordination?
- ☐ No
- ☐ Yes

Was the client interviewed for partner services?
- ☐ Yes, by a health department specialist
- ☐ Yes, by a non-health department person trained by the health department to conduct partner services
- ☐ No
- ☐ Don't know

Date of Interview

eHARS State Number *(ODH use only)*

New or Previous Diagnosis *(ODH use only)*
- ☐ New diagnosis, verified
- ☐ New diagnosis, not verified
- ☐ Previous diagnosis
- ☐ Unable to determine

→ Has the client seen a medical care provider in the past six months for HIV treatment?
- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Declined to Answer

Partner Services Case Number *(ODH use only)*

Value Definitions for New or Previous Positives

New Diagnosis, verified – The HIV surveillance system was checked and no prior report was found and there is no indication of a previous diagnosis by either self-report (if the client was asked) or review of other sources (if other sources were checked).

New Diagnosis, not verified – The HIV surveillance system was not checked and the classification of new diagnosis is based only on no indication of a previous positive HIV test by client self-report or review of other data sources.

Previous Diagnosis – Previously reported to the HIV surveillance system or the client reports a previous positive HIV test or evidence of a previous positive test is found on review of other data sources.

Unable to determine – The HIV surveillance system was not checked and no other data sources were reviewed and there is no information from the client about previous test results.

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Form ID (*enter or adhere)*

ODRS ID *(if applicable)* _____

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

10 | Essential Support Services *(complete for persons testing positive)*

	Screened for need	Need determined	Provided or referred
Navigation services for Linkage to HIV medical Care	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Linkage services to HIV medical care	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Medication adherence Support	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Health Benefits navigation and enrollment	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Evidence-based risk reduction and intervention	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Behavioral health services	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Social services	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes

Local Use Fields *(optional)*

Local Use Field 1
Local Use Field 2
Local Use Field 3
Local Use Field 4
Local Use Field 5
Local Use Field 6
Local Use Field 7
Local Use Field 8

Notes *(optional)*

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