

UDOH EVALUATIONWEB® HIV TEST FORM

PART TWO

Enter or adhere form ID									
Agency ID Name/Number*		Session Date *	M	M	D	D	Y	Y	Y

CDC requires the following information on all preliminary and confirmed HIV-positive clients:

Was the client referred to HIV medical care?

<input type="checkbox"/> No →  <input type="checkbox"/> Yes →  <input type="checkbox"/> Don't Know	Reason the client not referred to HIV Medical Care? <input type="checkbox"/> Client Already in Care <input type="checkbox"/> Client Declined Care
	Did the client attend the first appointment? <input type="checkbox"/> Pending
	<input type="checkbox"/> Confirmed: Accessed Service → <input type="checkbox"/> Confirmed: Did Not Access Service
	<input type="checkbox"/> Lost to Follow-Up <input type="checkbox"/> No Follow-Up <input type="checkbox"/> Don't Know

Local Use Fields

L5	#	#	#	#	#
L6	#	#	#	#	#
L7	#	#	#	#	#
L8	#	#	#	#	#
L9	#	#	#	#	#
L10	#	#	#	#	#
L11	#	#	#	#	#
L12	#	#	#	#	#
L13	#	#	#	#	#
L14	#	#	#	#	#
L15	#	#	#	#	#
L16	#	#	#	#	#
L17	#	#	#	#	#

Was the client referred to/contacted by Partner Services?

<input type="checkbox"/> No  <input type="checkbox"/> Yes →  <input type="checkbox"/> Don't Know	Was the client interviewed for Partner Services? <input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know
	Was the client interview within 30 days of receiving their result? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know

CDC Use Fields

C3	#	#	#	#	#
C4	#	#	#	#	#
C5	#	#	#	#	#
C6	#	#	#	#	#
C7	#	#	#	#	#
C8	#	#	#	#	#
C9	#	#	#	#	#

Was the client referred to HIV Prevention Services?

<input type="checkbox"/> No  <input type="checkbox"/> Yes →  <input type="checkbox"/> Don't Know	Did the client receive HIV Prevention Services? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
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What was the client's housing status in the past 12 months? (check all that apply)

<input type="checkbox"/> Literally Homeless <input type="checkbox"/> Imminently Losing Housing	<input type="checkbox"/> Unstably Housed and at Risk of Losing Housing <input type="checkbox"/> Stably Housed	<input type="checkbox"/> Not Asked <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Don't Know
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If female, is the client pregnant?

<input type="checkbox"/> No  <input type="checkbox"/> Yes →  <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	Is the client in prenatal care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
	<input type="checkbox"/> Declined <input type="checkbox"/> Not Asked

Notes:  
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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?

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know <input type="checkbox"/> Not Checked
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