CIF V.2 for Reactive Results

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

When writing letters or numbers, place one character in each box. For letters, use only capitals.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

Place Lab Sticker #1

Place Lab Sticker #2

Specimen Date: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

State Site Code : ☐☐☐☐☐☐☐☐

HIRS Client ID (HIRS Sites Only) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

HIRS Site Code : ☐☐☐☐☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Social Security Number : ☐☐☐ ☐☐ ☐☐☐☐

FINAL TEST RESULT

Note: This section is for informational purposes only

Final HIV Test Result:

- ○ Negative ○ Preliminary Positive (no confirmatory sample taken)
- ○ Positive ○ Inconclusive ○ Discordant ○ Invalid
- ○ Other, specify: ☐

CONFIRMATORY DISCLOSURE

Confirmatory Disclosure Scheduled?
○ Yes ○ No

Actual Confirmatory Disclosure Date: ☐☐ / ☐☐ / ☐☐☐☐

Counselor ID ☐☐☐☐☐

Reschedule Attempt Date for Confirmatory Test Result (Date Client was called (mm/dd/yyyy) : ☐☐ / ☐☐ / ☐☐☐☐

Counselor ID/Initials ☐☐☐☐☐

Reschedule Attempt Outcome:

- ○ Client returned for disclosure
- ○ Obtained HIV results elsewhere
- ○ Unable to locate/contact
- ○ Client declined notification
- ○ Rescheduled but did not return

HIV POSITIVE CLIENTS ONLY

HIV Positive Medical Referrals:

- ○ No Referrals provided
- ○ HIV Case Management
- ○ Early Intervention Program
- ○ Prenatal Care
- ○ Medical Services

  If Marked, please select at least three Medical Referrals below *
- ○ Client plans to use their own physician/health plan
- ○ Referrals offered but client declined referrals

Medical Visit verified?

Medical Visit Verified by Client: ○ Yes ○ No

Medical Visit Verified by Data: ○ Yes ○ No

Medical Visit Verified by Provider: ○ Yes ○ No

Medical Visit Date : (mm/dd/yy) ☐☐ / ☐☐ / ☐☐☐☐

Partner Services Discussed/Offered to Client?

- ○ No, Partner Services not discussed
- ○ Yes, client declined services
- ○ Yes, Partner Services activities this session (initial and indicate activities)

Partner Services Activities : (Mark all that apply) **Number of Partners**

- ○ Skill building with client for self notification ☐☐☐
- ○ Anonymous third party notification ☐☐☐
- ○ Dual client/partner session (Indicate # of Partners) ☐☐☐

Partner Services Counselor Initials ☐☐☐☐☐

County of Los Angeles Public Health

50134

* SELECT AT LEAST THREE MEDICAL REFERRALS

- ○ AIDS Health Care Foundation
- ○ AlltaMed Health Services
- ○ Children's Hospital Los Angeles
- ○ City of Long Beach Dept. Health & Human Svcs.
- ○ City of Pasadena - Health Services
- ○ East Valley Community Health Center
- ○ El Proyecto del Barrio
- ○ LAC + High Desert Hospital
- ○ LAC + Humphrey Comprehensive Health Center
- ○ LAC + Long Beach Comprehensive Center
- ○ LAC + Martin Luther King/Drew Medical Center
- ○ LAC + Olive View Medical Center
- ○ LAC + USC Maternal Child and Adolescent
- ○ LAC + USC Medical Center Rand Schrader
- ○ LAC + USC Medical Center Weingart Intervention Clinic
- ○ LAC+ Harbor/UCLA Medical Center
- ○ Long Beach Memorial Miller Medical Center
- ○ Northeast Valley Health Corporation
- ○ Los Angeles Gay & Lesbian Community Services Ctr - Jeffrey Goodman Clinic
- ○ St. Mary's Medical Center
- ○ Valley Community Clinic
- ○ Watts Health Foundation
- ○ Other medical referral, specify: ____

PREVENTION REFERRALS

- ○ No Referrals provided
- ○ Comprehensive Risk Counseling (CRCS)
- ○ HIV Education & Prevention Services
- ○ Follow-Up HIV Counseling
- ○ Prevention Skill Development
- ○ Prevention Support Group
- ○ Individual psychotherapy/counseling
- ○ HCV Medical Services
- ○ Post exposure prophylaxis
- ○ Hepatitis testing/vaccination
- ○ STD testing & treatment
- ○ TB testing & treatment
- ○ Other HIV testing
- ○ Syringe Exchange Program
- ○ Alcohol/drug treatment (detox, methadone, outpatient or residential)
- ○ Harm reduction services
- ○ Reproductive health services
- ○ Non-HIV/HCV medical services
- ○ Social services
- ○ Other referral, specify: ____

HIV Incidence - Positive Clients Only

Date Incidence Information Collected: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Date First Positive HIV Test: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Has Client Ever Tested Negative

○ Yes ○ No ○ Don't Know ○ Declined

Date Last HIV Negative Test: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Total # of HIV Tests before the first positive results

Today		Prior to today		Total
1	+		=	

Was the Client Exposed to Anti-retrovirals (ARV) in the previous six months?

○ Yes ○ No ○ Don't Know ○ Declined

If yes, please specify ARV medication:

ARV1	ARV2	ARV3	ARV4

Date ARV Started: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Date ARV Stopped: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

COUNSELOR NOTES