



POSITIVE RAPID HIV TEST REPORT

State Form 56671 (R / 3-19)
INDIANA STATE DEPARTMENT OF HEALTH

OPSCAN NO.:

CONFIDENTIAL INFORMATION

PATIENT

Last Name: _____ First Name: _____ MI: _____ Maiden Name: _____

Address: _____ City: _____ County: _____ ST: _____ ZIP: _____
(number and street)

Telephone: _____ SSN*: _____ Date of Birth: _____ Birth Country: _____
(mm/dd/yyyy)

Sex: M F T Race: _____ Hispanic: Yes No

ISDH ID NO.:

* This agency is requesting disclosure of your Social Security Number (SSN) in accordance with IC 4-1-8-1; disclosure is voluntary and you will not be penalized for refusal.

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Rapid HIV+ Test Date: _____
(mm/dd/yyyy)

1st RAPID (Finger Stick) TEST MANUFACTURER

- Abbot **DETERMINE** HIV-1/2 Ag/Ab Combo _____ Lot #
- bioLytical **INSTI** HIV-1/HIV-2 Ab _____ Lot #
- OraQuick **ADVANCE** HIV-1/HIV-2 Ab _____ Lot #
- Other _____ Lot #

1

Testing Agency: _____ Test Site/Location: _____

Tester Name Printed: _____ Tester Signature: _____ Date: _____
(mm/dd/yyyy)

REACTIVE 1st TEST FOLLOW-UP

- Blood draw completed and sent to lab. Drawn by Name: _____ Date: _____
(mm/dd/yyyy)
- Client referred/scheduled for blood draw. Agency: _____ Appt. Date/Time: _____
(mm/dd/yyyy) (time)

*****STOP and submit form at this point unless a second finger-stick rapid test is conducted during this encounter.*****

- Client tested with 2nd rapid blood-draw test. Complete below:

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Rapid HIV+ Test Date: _____
(mm/dd/yyyy)

2nd RAPID (Finger Stick) TEST MANUFACTURER

(Must be different brand of test from the first.)

- Abbot **DETERMINE** HIV-1/2 Ag/Ab Combo _____ Lot #
- bioLytical **INSTI** HIV-1/HIV-2 Ab _____ Lot #
- OraQuick **ADVANCE** HIV-1/HIV-2 Ab _____ Lot #
- Other _____ Lot #

Surveillance Only:

2

Testing Agency: _____ Test Site/Location: _____

Tester Name Printed: _____ Tester Signature: _____ Date: _____
(mm/dd/yyyy)

NON-REACTIVE 2nd TEST FOLLOW-UP

*****A non-reactive 2nd finger-stick requires a blood-drawn follow-up HIV lab test.*****

- Blood draw completed and sent to lab. Drawn by Name: _____ Date: _____
(mm/dd/yyyy)
- Client referred/scheduled for blood draw. Agency: _____ Appt. Date/Time: _____
(mm/dd/yyyy)

*****STOP and submit form after documenting the lab-draw blood HIV test conducted or scheduled during this encounter.*****

REACTIVE 2nd TEST FOLLOW-UP

*****The following steps should be conducted after any finger-stick or lab based positive 2nd test.*****

Individual completing this section: Printed Name: _____ Telephone: _____

- State HIV Case report has been completed and sent.
 - Client has been informed of HIV infection.
 - DIS has been contacted to engage partner services.
 - Client has been educated on: viral suppression; ART; PrEP; U=U; tissue donation; partner notification; and State HIV law - IC 16-41-7-1.
- Referrals made to the following: Care Coordination Medical Health Mental Health Substance Use Other: