CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

Beta v2.5

HIV and HCV Rapid Testing Case Reporting Guidance for DPH Funded Sites

February 2024

CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

Procedure for Reporting **Newly or Previously Confirmed HIV Positive Cases to DPH:**

a. Complete HIV Test Form Template for all confirmed HIV positive results (See Appendix A). If your site would like a copy of the test template e-mailed, please contact Luis Diaz at luis.diaz@ct.gov.

b. Submit all completed confirmed **HIV positive EvaluationWeb 2018 HIV Test Template Forms** to the CT DPH HIV Prevention Program and e-mail Luis Diaz at luis.diaz@ct.gov when the HIV positive EvaluationWeb 2018 HIV Test Template Forms are sent:

   i. DPH funded and/or supported HIV testing programs should send all confirmed HIV positive Test Forms to DPH, attention to Luis Diaz. A confirmatory email will be sent to programs submitting HIV Test Forms to ensure the receipt of the forms. **Programs can fax forms to 860-730-8404 (RightFax)** or Mail forms to:

   CT DPH
   HIV Prevention
   410 Capitol Ave
   MS#11APV
   Hartford, CT 06134-0308

c. Report to the CT DPH HIV Surveillance Program all confirmed HIV positive results on the Adult HIV Case Report Form (See Appendix B or the links below) via: Adult HIV Case Report Form (https://tinyurl.com/AdultHIVCaseReportFormCT)

1) Phone:

CT DPH HIV Surveillance Program
860-509-7900

OR

2) Mail:

Connecticut Department of Public Health
410 Capitol Ave
P.O. Box 340308, MS #11APV
Hartford, CT 06134-0308

If an HIV Testing in Clinical Settings or HIV Testing in Non-clinical Settings (directly or non-directly funded) site **is not using** the CT DPH State Laboratory for HIV Testing confirmatory results, providers must submit proof of confirmatory result along with the Adult HIV/AIDS Confidential Case Report Form to the CT DPH HIV Surveillance Program.

d. For HIV Testing sites using the CT DPH State Laboratory:

If an HIV testing Program (directly or non-directly funded) site **is using** the CT DPH State Laboratory for HIV Testing Confirmatory results, providers must submit one tube of whole blood, serum or plasma to the CT DPH State Laboratory. Use of Orasure has been discontinued by the CT DPH Lab.

Note. **Copies of the HIV Test Forms for both positive and negative test events must be kept on file at the site and secured in a locked file cabinet.**

e. Report the case to Partner Services (Appendix C). Complete the Partner Service Reporting Forms. Contact the Partner Services Contact in your area. Partner Services Forms can be faxed to RightFax at 860-730-8380.
Client Referral Form
Partner Referral Form
Checklist for Referral to Partner Services

Procedure for Reporting **Hepatitis C Rapid Testing Positive Cases to DPH:**

Complete the HCV Rapid Test Report Form for all Hepatitis C tests performed by HIV Prevention Contractors (See Appendix D).

- Negative HCV Rapid Test Results **DO NOT** need to be reported to the DPH HCV Program using the attached form.
- Positive HCV Rapid Test Results need to be reported to the HCV Program using the revised HCV Rapid Test Report form.
- T**he positive test results can be faxed to 860-730-8404 (RightFax)**

- Please do not email any results

- Enter **all** HCV test results (positive and negative) into EvaluationWeb.

Reporting Do's and Don'ts

Do's:

- ✓ Send the completed 2020 HIV Test Forms
- ✓ Include Client ID and Year of Birth for all positive test forms
- ✓ Client ID = First and Third letter of the First Name + First and Third of Last Name + Date of Birth (MM/DD/YY) + Gender 1 (Male), 2 (Female), 3 (Transgender), 4 (MTF), 5 (FTM), 9 (Unknown), 6 (Refused).
- ✓ Ensure that forms are completed appropriately
- ✓ Send Luis Diaz an e-mail when forms are sent
- ✓ Mail or fax forms as soon as possible
- ✓ Include name and return address on envelopes or fax cover sheet
- ✓ Use the most current HIV Test Forms
- ✓ Make copies of the HIV Test Forms for your records
- ✓ Contact DPH HIV Prevention and HIV Surveillance Programs, if you have any questions regarding submitting all required information

Don'ts:

- ☒ Mail confidential personal health information (PHI) to the HIV Prevention Program that includes any demographic information such as name, date of birth, address, gender, etc.
- ☒ Submit any HIV Test Forms without Form ID Labels

APPENDICES

APPENDIX A

EvaluationWeb® 2018 HIV Test Template

Form ID *(enter or adhere)*

1 Agency and Client Information
(complete for ALL persons)

Session Date

Program Announcement

- ◯ PS15-1506 PrIDE
- ◯ PS15-1509 THRIVE
- ◯ PS17-1711
- ◯ PS18-1802
- ◯ PS18-1802 Demonstration Projects
- ◯ PS19-1901 CDC STD
- ◯ Other CDC funded
- ◯ Other non-CDC funded

Specify Other *(optional)*

Agency Name or ID

Site Name or ID

Site Type *(codes below)*

Site ZIP Code

Site County *(3-digit FIPS code)*

Local Client ID *(optional)*

Year of Birth *(1800 if unknown)*

Client State *(USPS abbreviation)*

Client County *(3-digit FIPS code)*

Client ZIP Code

Client Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Don't Know
- ◯ Declined

Client Race *(select all that apply)*

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

Client Assigned Sex at Birth

- ◯ Male
- ◯ Female
- ◯ Declined to Answer

Client Current Gender Identity

- ◯ Male
- ◯ Female
- ◯ Transgender Male to Female
- ◯ Transgender Female to Male
- ◯ Transgender Unspecified
- ◯ Declined to Answer
- ◯ Another Gender

Has the client had an HIV test previously?

- ◯ No
- ◯ Yes
- ◯ Don't Know

Site Types: Clinical

- F01.01 - Inpatient hospital
- F02.12 - TB clinic
- F02.19 - Substance abuse treatment facility
- F02.51 - Community health center
- F03 - Emergency department
- F08 - Primary care clinic (other than CHC)
- F09 - Pharmacy or other retail-based clinic
- F10 - STD clinic
- F11 - Dental clinic
- F12 - Correctional facility clinic
- F13 - Other

Site Types: Mobile

- F40 - Mobile Unit

Site Types: Non-clinical

- F04.05 - HIV testing site
- F06.02 - Community setting - School/educational facility
- F06.03 - Community setting - Church/mosque/synagogue/temple
- F06.04 - Community Setting - Shelter/transitional housing
- F06.05 - Community setting - Commercial facility
- F06.07 - Community setting - Bar/club/adult entertainment
- F06.08 - Community setting - Public area
- F06.12 - Community setting - Individual residence
- F06.88 - Community setting - Other
- F07 - Correctional facility - Non-healthcare
- F14 - Health department - Field visit
- F15 - Community Setting - Syringe exchange program
- F88 - Other

Form Approved: OMB No. 0920-0696, Exp. 02/28/2019. Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-79, Atlanta, Georgia, 30333, ATTN: PRA 0920-0696. CDC 50.135b(E),10/2007

Form ID *(enter or adhere)*

2 Final Test Information *(complete for ALL persons)*

HIV Test Election

◯ Anonymous ◯ Confidential ◯ Test Not Done

Test Type *(select one only)*

◯ CLIA-waived point-of-care (POC) Rapid Test(s)

◯ Laboratory-based Test

POC Rapid Test Result *(definitions on page 3)*	Laboratory-based Test Result
◯ Preliminary Positive	◯ HIV-1 Positive
◯ Positive	◯ HIV-1 Positive, possible acute
◯ Negative	◯ HIV-2 Positive
◯ Discordant	◯ HIV Positive, undifferentiated
◯ Invalid	◯ HIV-1 Negative, HIV-2 Inconclusive
	◯ HIV-1 Negative
	◯ HIV Negative
	◯ Inconclusive, further testing needed

Result provided to client?

◯ No ◯ Yes ◯ Yes, client obtained the result from another agency

3 Negative Test Result *(complete for persons testing NEGATIVE for HIV)*

Is the client at risk for HIV infection?

◯ No ◯ Yes ◯ Risk Not Known

Was the client screened for PrEP eligibility?

◯ No ◯ Yes ◯ Not Assessed

Is the client eligible for PrEP referral?

◯ No ◯ Yes, by CDC criteria ◯ Yes, by local criteria or protocol

Was the client given a referral to a PrEP provider?

◯ No ◯ Yes

Was the client provided with services to assist with linkage to a PrEP provider?

◯ No ◯ Yes

4 Positive Test Result *(complete for persons testing POSITIVE for HIV)*

Did the client attend an HIV medical care appointment after this positive test?

◯ Yes, confirmed ◯ No

◯ Yes, client/patient self-report ◯ Don't Know

→ Date Attended

Has the client ever had a positive HIV test?

◯ No ◯ Yes ◯ Don't Know

→ Date of first positive result

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

What was the client's most severe housing status in the last 12 months?

◯ Literally homeless ◯ Not Asked

◯ Unstably housed or at risk of losing housing ◯ Declined to Answer

◯ Stably housed ◯ Don't Know

If the client is female, is she pregnant?

◯ No ◯ Declined to Answer

◯ Yes ◯ Don't Know

→ Is the client in prenatal care?

◯ No ◯ Not Asked

◯ Yes ◯ Declined to Answer

◯ 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 for perinatal HIV service coordination?

◯ No ◯ Yes

Form ID *(enter or adhere)*

5 Additional Tests *(complete for ALL persons)*

Was the client tested for co-infections?
○ No ○ Yes

Tested for Syphilis?
○ No ○ Yes

Syphilis Test Result
○ Newly Identified Infection
○ Not Infected
○ Don't Know

Tested for Gonorrhea?
○ No ○ Yes

Gonorrhea Test Result
○ Positive ○ Negative ○ Don't Know

Tested for Chlamydial infection?
○ No ○ Yes

Chlamydial infection Test Result
○ Positive ○ Negative ○ Don't Know

Tested for Hepatitis C?
○ No ○ Yes

Hepatitis C Test Result
○ Positive ○ Negative ○ Don't Know

Value Definitions for POC Rapid Test Results

Preliminary positive - One or more of the same point-of-care rapid tests were reactive and none are non-reactive and no supplemental testing was done at your agency

Positive - Two or more different (orthogonal) point-of-care rapid tests are reactive and none are non-reactive and no laboratory-based supplemental testing was done

Negative - One or more point-of-care rapid tests are non-reactive and none are reactive and no supplemental testing was done

Discordant - One or more point-of-care rapid tests are reactive and one or more are non-reactive and no laboratory-based supplemental testing was done

Invalid - A CLIA-waived POC rapid test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport

6 PrEP Awareness and Use/Priority Populations *(complete for ALL persons)*

Has the client ever heard of PrEP (Pre-Exposure Prophylaxis)?
○ 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

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 injected drugs or substances?
○ No ○ Yes

7 Essential Support Services *(complete for ALL persons, EXCEPT as indicated)*

	Screened for need	Need determined	Provided or referred
Navigation services for linkage to HIV medical care *(positive only)*	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Linkage services to HIV medical care *(positive only)*	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Medication adherence support *(positive only)*	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
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

APPENDIX B

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at diagnosis)

Prior Dx	Surveillance Method	Report Source	STATE #	HARMS #	WEEK	YEAR	LexNex
YR: Site:	☐A ☐P ☐F ☐U					20___	

PATIENT IDENTIFIER INFORMATION

MR #_____ SSN #_____

Patient Name: _____ **Phone**: ( ) _____ - _____

(LAST, FIRST, MI)

Address:_____ **City**: _____ **County**: _____ **State**: ____ **Zip**: _____

PROVIDER INFORMATION

Provider Name: _____ **Phone**: ( ) _____ - _____

Facility: _____ **City**: _____ **State**: _____ **Zip**: _____

FORM INFORMATION

Date Completed: ___/___/_____ **Person reporting**: _____ **Phone**: ( ) _____ - _____

DEMOGRAPHIC INFORMATION

Diagnostic Status:	Date of Birth:	Current Status:	Date of Death:	State/Terr Death:
☐HIV Infection ☐AIDS	/ /	☐Alive ☐Dead ☐Unkn	/ /	

Sex at birth:	Current Gender Identity:	Ethnicity: (select one)	Race: (select one or more)	Country of Birth:
☐Male ☐Female	☐Male ☐Female ☐Trans Male-to-Female ☐Trans Female-to-Male ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown	☐Black or African Am ☐White ☐Asian ☐American Indian/Alaskan ☐Hawaiian/Other Pacific Islander ☐Unkn	☐US ☐Other _____ ☐Unknown

Residence at Diagnosis: Same as CURRENT address ☐

City:_____ **County**: FFLD HTFD LITCH NH NL MDX TLND WIND **State**: _____ **Zip**: _____

FACILITY OF DIAGNOSIS

Facility Name:

☐Inpatient ☐Outpatient ☐Other_____

City:

State/Country:

Identification Method: ☐Lab Report ☐Lab Audit ☐Viral Load ☐ICD-9 ☐Other:

Report Medium: Paper: ☐Field ☐Mail ☐Faxed ☐Phoned ☐Electronic transfer ☐Disc

RISK FACTOR HISTORY

Before the 1st positive HIV test, this patient had:

☐Sex with male ☐Sex with female Injected drugs: ☐Yes ☐No ☐Unknown

☐Other:

HETEROSEXUAL relations with the following:

☐IDU ☐Bisexual male ☐Person with documented HIV infection

☐Person w/ hemophilia ☐Transfusion/transplant recipient

Date of transfusion or transplant: / /

☐Worked in health-care or clinical lab setting

☐Congenital

☐**NO IDENTIFIED RISK (NIR)**

HIV TESTING HISTORY

Source: ☐Patient ☐Interview ☐Chart abstraction ☐Provider report ☐CW/XPEMS ☐Other

Date patient answered questions: _____/____/_____

Ever had a previous positive HIV test? ☐Yes ☐No ☐Unknown

Date of first positive HIV test: _____/____/_____

Has the patient ever had a *negative* HIV test? ☐Yes ☐No ☐Unknown

Date of the LAST negative HIV test: _____/____/_____

Number of HIV tests in the past 2 years: _____

ANTIRETROVIRAL USE HISTORY

Has the patient ever used antiretroviral medicines? ☐YES ☐NO ☐UNKN

ARV Use Type	ARV Medication	Date Began	Date last used
☐HIV Tx			
☐PrEP			
☐PEP			
☐PMTCT			
☐HBV Tx			
☐Other			

(HIV Tx – HIV treatment; PrEP - PRE-exposure prophylaxis; PEP - POST-exposure prophylaxis; PMTCT - prevention of mother-to-child transmission; HBV Tx – Hepatitis B treatment)

Laboratory Data

☐ Acute

HIV Antibody Tests (Non-type-differentiating)	RESULT	COLLECTION DATE
Test 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-2 IA ☐ Other _____	☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Rapid test? ☐ Yes ☐ No	/ /
HIV Antibody Tests (Type-differentiating)		
Test 2: ☐ Multispot ☐ Geenius ☐ Other _____	☐ HIV-1 ☐ HIV-2 ☐ Both HIV-1 and HIV-2 ☐ Neither (negative) ☐ Indeterminate	/ /
HIV Detection Tests (Quantitative)		
Test 3: ☐ HIV-1 RNA ☐ HIV-1 DNA NAAT ☐ Other _____	☐ Undetectable ☐ Det: _____ c/mL	/ /
HIV Detection Tests (Qualitative)		
Test 3: ☐ HIV-1 RNA/DNA NAAT ☐ HIV-1 Culture ☐ HIV-1 P24 Antigen ☐ HIV-2 RNA/DNA NAAT ☐ HIV-2 Culture	☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate	/ /

Why was the patient tested for HIV?

☐ Symptoms/dx w/ OI ☐ Routine test ☐ Pre-exposure medication (PrEP) screening ☐ Rule out HIV ☐ 'Just checking'
☐ Partner dx w/ HIV ☐ Regular tester ☐ Dx with STD ☐ Prenatal screening ☐ Establish Care ☐ Other:

Immunologic Testing:	
Closest to current diagnostic status:	COLLECTION DATE
CD4 count _____ cells/ul _____%	/ /
FIRST <200 or <14% of total lymphocytes:	
CD4 count _____ cells/ul _____%	/ /

HIV Genotype done?	COLLECTION DATE
☐ YES, Lab:_____ ☐ No	/ /

Physician Diagnosis:	
If HIV lab tests were not available, is HIV diagnosis documented by a physician?	☐ Yes ☐ No
If **YES**, provide date of documentation:	/ /

Clinical Status

Clinical Record Reviewed? ☐ Yes ☐ No AIDS INDICATOR DISEASES:	**Initial Dx Date** (mo/day/yr)	Presumptive	Definitive
Candidiasis, esophageal	/ /	☐	☐
Kaposi's sarcoma	/ /	☐	☐
M. tuberculosis	/ /	☐	☐
Pneumocystis jiroveci pneumonia	/ /	☐	☐
Pneumonia, recurrent	/ /	☐	☐
Toxoplasmosis of brain	/ /	☐	☐
Wasting syndrome due to HIV	/ /	☐	☐
Other:	/ /	☐	☐

Referrals

Has the patient been informed of their HIV results?	☐ Yes ☐ No ☐ Unkn
This patient's partners will be notified about their HIV exposure and counseled by: ☐ Physician/provider ☐ Patient ☐ Unknown ☐ Not applicable	This patient's medical treatment is primarily reimbursed by: ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ No coverage ☐ Other public funding ☐ Clinical trial/program ☐ Unknown

Where was the patient referred for HIV Care?

Provider Name:_____

Facility: _____

Health care providers can request assistance for notification of potentially exposed partners.

Would you like this assistance from DPH? ☐ Yes ☐ No

For Female Patients

Is patient receiving or been referred for OB/GYN services?	☐ Yes ☐ No ☐ Unkn
Is this patient currently pregnant?	☐ Yes ☐ No ☐ Unkn
If 'YES', when is the due date?	/ /
Where is the patient scheduled to deliver?	Hospital:

Comments: _____

_____

_____ 4.16

CLIENT REFERRAL FORM FOR PARTNER SERVICES

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STD CONTROL PROGRAM

ATTN:_____ **DATE:**_____

AGENCY/ORGANIZATION INFORMATION

REFERRAL SITE (NAME): _____

☐ DOC ☐ ETI ☐ EIS ☐ MCM ☐ OTL ☐ OTHER:_____

PERSON REFERRING (NAME & TITLE): _____

PHONE NUMBER:_____ E-MAIL: _____

REASON FOR REFERRAL

☐ Newly diagnosed HIV client, diagnosed within the last 12 months. **FormID/PFL#:** _____

Client was infected more than 12 months ago and:

☐ Has a new reportable STD diagnosis, infected within the last 3 months.

☐ Unprotected sex within the last 3 months with multiple partners and/or anonymous partner(s) and/or new partner(s).

☐ Known partners are unaware of the client's status, client is having sex after HIV diagnosis.

☐ Client is requesting partner services for a new partner.

CLIENT INFORMATION (complete all of the information below)

NAME (LAST, FIRST):_____ DOB:_____

GENDER: ☐ M ☐ F ☐ MTF ☐ FTM ☐ Unk PRIMARY LANGUAGE: _____

MARITAL/RELATIONSHIP STATUS: ☐ S ☐ M ☐ Div ☐ Sep ☐ W ☐ Cohab ☐ Unk

ETHNICITY: ☐ Hispanic ☐ Not Hispanic

RACE (check all that apply): ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African Am.
☐ Native Hawaiian/Other PI ☐ White ☐ Unk

STREET ADDRESS: _____

CITY/TOWN STATE ZIP CODE

PHONE NUMBERS (home/cell):_____ E-MAIL:_____

WEBSITES/PHONE APPS: _____

PHYSICAL DESCRIPTION: _____

GENDER OF SEX PARTNERS (check all that apply): ☐ M ☐ F ☐ MTF ☐ FTM ☐ Unk

RISK FACTORS: ☐ MSM ☐ IDU ☐ Exchanges sex for drugs or money
☐ Other: _____

DATE OF HIV DIAGNOSIS:_____ DATE OF LAST NEGATIVE HIV TEST: _____

HIV Medical Care Physician:_____ **Phone #**: _____

If DOC Referral, what is the earliest date this client may be released from custody? _____

If information on partners is available, complete page 2, Partner Referral form for Partner Services for each partner.

***Note:* Prior to sending any fax, please contact Kelly Russell, Disease Intervention Specialist Supervisor at (860) 558-9514 or (860) 509-7899. Fax completed forms, with a coversheet from your agency marked *ATTN: Kelly Russell*, to (860) 730-8380.**

DO NOT E-MAIL THIS FORM

PARTNER REFERRAL FORM FOR PARTNER SERVICES

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STD CONTROL PROGRAM

ATTN:_____ **DATE:**_____

AGENCY/ORGANIZATION INFORMATION

REFERRAL SITE (NAME): _____

☐ DOC ☐ ETI ☐ EIS ☐ MCM ☐ OTL ☐ OTHER:_____

PERSON REFERRING (NAME & TITLE): _____

PHONE NUMBER:_____ E-MAIL: _____

PARTNER INFORMATION (complete all of the information below)

NAME (LAST, FIRST):_____ DOB:_____

GENDER: ☐ M ☐ F ☐ MTF ☐ FTM ☐ Unk PRIMARY LANGUAGE: _____

MARITAL/RELATIONSHIP STATUS: ☐ S ☐ M ☐ Div ☐ Sep ☐ W ☐ Cohab ☐ Unk

ETHNICITY: ☐ Hispanic ☐ Not Hispanic

RACE (check all that apply): ☐ Am. Indian/Alaska Native ☐ Asian ☐ CheckBox1

STREET ADDRESS: _____

CITY/TOWN STATE ZIP CODE

PHONE NUMBERS (home/cell):_____ E-MAIL: _____

WEBSITES/PHONE APPS: _____

PHYSICAL DESCRIPTION: _____

RISK FACTORS: ☐ MSM ☐ IDU ☐ Exchanges sex for drugs or money
☐ Unaware of Client's status ☐ Other: _____

EXPOSURE TYPE(S):
Check all that apply in the table below and complete information about each type of exposure this Partner had to the Client (see page 1, *Client Referral Form for Partner Services*).

Exposure Information	☐ *Sex*	☐ *Syringe/ works sharing*	☐ *Other, specify:*
Date first contact (mm/dd/yyyy)			
Date last contact (mm/dd/yyyy)			
Frequency (e.g., two times per week)			

COMMENTS: _____

_____

_____

_____

***Note:* Prior to sending any fax, please contact Kelly Russell, Disease Intervention Specialist Supervisor at (860) 558-9514 or (860) 509-7899. Fax completed forms, with a coversheet from your agency marked *ATTN: Kelly Russell*, to (860) 730-8380.**

DO NOT E-MAIL THIS FORM

APPENDIX D

Connecticut Department of Public Health Hepatitis C Program

HCV Rapid Test Report Form – Positive Results Only!

Agency Name: _____ **Date:** _____

Full Name of HCV Tester: _____ **Phone:** (____) _____

Patient information

Name: _____ **DOB:** _____ **Phone:** (____) _____

Street address: _____ **City:** _____ **State:** _____ **Zip:**_____

Country of birth: □ USA □ Unknown □ Other (specify): _____

Client Assigned Sex at Birth: □ Male □ Female □ Declined to Answer

Client Current Gender Identity: □ Male □ Female □ Transgender Male to Female □ Transgender Female to Male □ Transgender Unspecified □ Another Gender: _____ □ Declined to Answer

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Race: □ Black □ White □ Asian Hawaiian/PI □ American Indian □ Unknown □ other (specify): _____

Person Previously Diagnosed with HCV? □ No □ Yes □ Unknown

HCV Rapid Test Result	Result	Date
Antibody Rapid Test	Positive	
Referred for PCR test: □ No □ Yes		
PCR Test Result (if referred):	□ Negative □ Positive	

Risk Factors (check all that apply):	Yes	No	Unknown	Notes
Blood transfusion prior to 1992				
Organ transplant prior to 1992				
Clotting factors prior to 1987				
Long term hemodialysis				
Employed in a medical/dental field involving direct contact with blood				
Injection drug use, past or present (even if only once)				
Used street drugs but did not inject				
History of incarceration				
Tattoo				
Household contact of a person who had Hepatitis C, non-sexual				
Sexual contact with a person who had Hepatitis C				
Treated for a sexually transmitted disease				
Man who has sex with men				
Other risk specify:				
Number of sex partners (lifetime):				

Please send via RightFax to 860-730-8404 or mail in an envelope marked confidential to:

Luis Diaz
CT DPH, 410 Capitol Ave, MS #11APV, Hartford CT 06134
For more information, e-mail Luis Diaz at luis.diaz@ct.gov

CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

If you have any questions regarding the reporting of HIV positives cases to the CT DPH, please contact:

Susan Major, Health Program Supervisor

Email: susan.major@ct.gov