STI/HIV Counseling & Testing
Preliminary Positive Rapid HIV Report Form

Patient's Name: _____
Last **First** **Middle**

Home/Cell Phone: _____ **Work Phone:** _____

Residential Address: _____

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

Sex at Birth: ☐ **M** ☐ **F** **Date of Birth:** _____/_____/_____

Gender Identity: ☐ **M** ☐ **F** ☐ **TG - MTF** ☐ **TG - FTM** ☐ **TG - Other** ☐ **Declined**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Declined**

Race: *(Check all that apply)*

☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Declined**

Disease Name: **Rapid HIV Test – Preliminary Positive**

Test Result (please check one):

☐ **Antigen Reactive** ☐ **Antibody Reactive** ☐ **Antigen/Antibody Reactive**

Has this patient been notified of the test result? ☐ **Yes** ☐ **No**

Was a confirmatory test drawn? ☐ **Yes** ☐ **No**

Facility Name: _____

Testing Counselor Name: _____

Session Date: _____/_____/_____ **HIV Test Form Client ID #:**_____

HIV Evaluation Web Form ID #:_____

Which Linkage to Care Coordinator was the client referred to?

Sara Weckhorst
Cell: (785) 213-6851

April Shilling
Cell: (316) 570-1617

Fax report to the STI/HIV Prevention Program (785) 559-4229
within 24 hours of session date/time.

Revised 2019-1-22