

HIV TESTING REFERRAL AND RESULTS FORM

Date: _____

PART 1 – REFERRAL (To be completed by DCF Social Worker. Complete a separate request for each **sibling** who requires HIV testing.)

Area HIV Monitor/Designee: _____ Area Office: _____

Social Worker: _____ Telephone: _____ Person ID: _____ Case ID: _____

Child's Name: _____ DOB: _____ Legal Status: C+P CHINS VPA

Child's Current Primary Care Provider: _____ Telephone: _____

Previous HIV Testing done? Yes No Unknown If Yes, Date of Testing: _____ Results of Testing: _____

REASON(S) FOR HIV TESTING

1. Is the child's sibling HIV+ or been diagnosed with AIDS? Yes No Unknown
2. Is the child known to have used illegal drugs? Yes No Unknown
3. Positive drug screen at birth for illegal drugs? Yes No Unknown
If yes, what drug(s)? _____
4. Has the child had multiple sex partners or engaged in prostitution? Yes No Unknown
5. Has the child been sexually abused? Yes No Unknown
6. Has the child been diagnosed with a sexually transmitted disease? Yes No Unknown
7. Has the child engaged in unsafe sex practices or sexual activity with multiple partners, or is the child pregnant? Yes No Unknown
8. Has the child received a transfusion between January, 1978 and July, 1985? Yes No Unknown
9. Has the child received a bite or bitten another person and broken the skin? Yes No Unknown
10. Has the child lived in a country where the safety of blood or blood products is unknown, and received a transfusion there? Yes No Unknown
11. Is information regarding risk factors unavailable? Yes No Unknown
12. Was the child abandoned at birth? Yes No Unknown
13. Has the child engaged in self-injury or cutting behaviors? Yes No Unknown
14. Current illnesses or symptoms: _____

	Mother	Mother's Partner(s)	Father	Father's Partner(s)
Diagnosed with AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Prostitution, Multiple sex partners, Unsafe sex practices	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diagnosed with Sexually Transmitted Disease(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Used illegal drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HIV Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Other relevant child/sibling/family medical history: _____

Additional information/comments (if any): _____

PART 2 – RECOMMENDATIONS FOR HIV TESTING

HIV Testing recommended? YES NO _____
Name of Area Office Designee Area Office Address & Fax Number

PART 3 – HIV TESTING OUTCOME – TO BE COMPLETED BY MEDICAL PROVIDER

PROVIDER: Please complete below. Return form to DCF Area Office Designee at address or fax number in Part 2 above.

Test date: _____ Test result: _____ Test not completed; reason: _____

Medical Provider Name & Address (PLEASE PRINT) Medical Provider Signature Date