HIV VERIFICATION FORM

CONFIDENTAL

This form should be provided to a medical or service provider chosen, by the client, to verify they have received two reactive rapid HIV test results.

LAST NAME	**FIRST NAME**	
PHONE	**GENDER**	**D.O.B.**
COLLECT DATE	**TIME**	

1st Rapid Test _____	Negative ☐	Positive ☐
2nd Rapid Test _____	Negative ☐	Positive ☐

TEST SITE	
CITY	**PHONE**
TESTER NAME	**CTR TESTING #**
TESTER SIGATURE	

Rapid HIV testing considerations:

- If the 1st rapid test is **NEGATIVE**, the screen is considered negative for HIV antibodies
- If the 1st rapid test is **POSITIVE**, confirmatory testing (molecular tests) from an outside laboratory or a second rapid test is recommended.
  - If two different rapid tests have been performed and are **both POSITIVE**:
    - Based on current CDC guidelines, the patient is **considered positive for HIV and has been referred for care.** Additional testing may be performed by the provider to evaluate for treatment options.
  - If two different rapid tests have been performed with the **second test NEGATIVE**:
    - The results are **DISCORDANT** and require further investigation. Refer to an outside laboratory or provider for confirmatory testing; recommend follow-up testing in 1-2 weeks; or provide rapid linkage for confirmatory.

Dear Provider: This information has been disclosed to you from confidential records protected from disclosure by state laws. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or otherwise permitted by state laws. A general authorization for the release of medical or other information is not sufficient for the release of HIV test results or diagnoses

For assistance with test interpretation, contact:
Ohio Department of Health/HIV Prevention
246 North High Street, 6th Floor
Columbus, OH 43266-0588
PHONE: 614.995.5599 FAX: 614.728.0876
HIVPrevention@odh.ohio.gov