



# HIV TESTING

HTS

The Department of Health (DOH) has an existing program for the prevention and control of the Human Immunodeficiency Virus (HIV) in the Philippines. The Epidemiology Bureau (EB) of DOH is mandated by Republic Act 11166 & 11332 to collect information that will be used in planning activities to help stop the spread of HIV and to support and treat those diagnosed with HIV. Your full cooperation is very important to this program. Please answer all questions as honestly as possible.

### ABOUT THE TEST

#### What is HIV testing?

An HIV test refers to a procedure used to identify if you have antibodies to HIV -- the virus that causes AIDS. A specimen, usually blood, and a DOH-Food and Drug Administration (FDA)-registered diagnostic kit is needed to perform the test. The test may be performed by a trained/supervised healthcare worker or lay person, or by oneself, depending on the modality.

If the first test (screening) is reactive, another test (confirmatory) will be done to make sure that the first test is confirmed to be positive. A positive test means you have been infected with HIV. A non-reactive or negative test means you are not infected or your body has not produced the sufficient level of antibodies (within window period) that can be detected by the HIV rapid diagnostic test kits. If you are non-reactive or negative, and had a recent exposure within the window period, you need to undergo another test 4 weeks after your risk exposure.

#### Confidentiality of HIV Testing

Your personal information and HIV test result is confidential adherent to the provisions of RA 11166 Philippine HIV and AIDS Policy Act, RA 10173 Data Privacy Act of 2012 and its IRR of 2016.

### INFORMED CONSENT

I, CLIENT / CHILD / PROXY CONSENT PROVIDER, was given information about HIV, its testing process, and was able to ask questions about HIV. I agree to undergo HIV testing.

\_\_\_\_\_  
Name and Signature

**Verbal Consent**  
(applicable for clients 15 y/o and above undergoing either CBS or self-testing)

By providing my contact details, I am allowing the HTS provider to contact me on updates regarding the services provided including but not limited to: test result, combination prevention services, and notification for retesting.

Contact Number: \_\_\_\_\_

Email address: \_\_\_\_\_

### PERSONAL INFORMATION SHEET (HTS FORM)

All information given will be **STRICTLY CONFIDENTIAL**. Please fill out this form **COMPLETELY** and as honestly as possible. Please write in **CAPITAL LETTERS** and **CHECK** the appropriate boxes.

#### DEMOGRAPHIC DATA

1	Test Date:	<input type="text"/> <input type="text"/> <input type="text"/>	Month	Day	Year	
2	PhilHealth Number:	<input type="text"/> - <input type="text"/>				<input type="checkbox"/> Not enrolled in PhilHealth
3	PhilSys Number:	<input type="text"/>				<input type="checkbox"/> No PhilSys Number
4	Name (Full name)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	First Name Middle Name Last Name Suffix (Jr, Sr, III, etc)
5	First 2 letters of mother's FIRST name	<input type="text"/>	First 2 letters of father's FIRST name	<input type="text"/>	Birth order (i.e. among mother's children)	<input type="text"/>
6	Birth date:	<input type="text"/> <input type="text"/> <input type="text"/>	Month	Day	Year	Age: <input type="text"/> <input type="text"/> Age in months (for less than 1 year old): <input type="text"/> <input type="text"/>
7	Sex (assigned at birth):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Gender identity:	<input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Others: _____		
8	Current Place of Residence:	City/Municipality: _____ Province: _____	Permanent Residence:	City/Municipality: _____ Province: _____	Place of Birth:	City/Municipality: _____ Province: _____
9	Nationality:	<input type="checkbox"/> Filipino <input type="checkbox"/> Other, please specify: _____				
10	Civil Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				
11	Are you currently living with a partner?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Number of children:	<input type="text"/> <input type="text"/>		
12	Are you currently pregnant? (for female clients only)	<input type="checkbox"/> No <input type="checkbox"/> Yes				

#### EDUCATION & OCCUPATION

13	Highest Education Attainment?	<input type="checkbox"/> No grade completed <input type="checkbox"/> Pre-school <input type="checkbox"/> Highschool <input type="checkbox"/> Vocational <input type="checkbox"/> Elementary <input type="checkbox"/> College <input type="checkbox"/> Post-Graduate
14	Are you currently in school?	<input type="checkbox"/> No <input type="checkbox"/> Yes
15	Are you currently working?	<input type="checkbox"/> Yes. Current occupation (main source of income): _____ <input type="checkbox"/> No. Previous occupation in the past 12 months: _____
16	Did you reside or work overseas/abroad in the past 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes Did you work overseas/abroad? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify year of return from last contract: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Where were you based? <input type="checkbox"/> On a ship <input type="checkbox"/> Land What country did you last work in? (For seafarer, last port of exit) _____



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You may answer this on your own or with assistance from a counselor or healthcare provider

## HISTORY OF EXPOSURE / RISK ASSESSMENT

Answer all. Please check the appropriate column for each item, and provide history of risk if applicable.

Did your birth mother have HIV when you were born?  Do not know  No  Yes

	History of sexual activity (oral/anal/vaginal)		Date of most recent <b>anal or neo/vaginal</b> sex (MM/YYYY)	Date of most recent <b>CONDOMLESS</b> anal or neo/vaginal sex (MM/YYYY)
	No	Yes		

Sex with a **MALE\***  No  Yes

Sex with a **FEMALE\*\***  No  Yes

\*Sex partners whose assigned sex at birth is MALE, including transgender and/or nonbinary

\*\*Sex partners whose assigned sex at birth is FEMALE, including transgender and/or nonbinary

	No	Yes	Date of most recent risk (MM/YYYY)
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Paid for sex (in cash or kind)  No  Yes

Received payment (cash or in kind) in exchange for sex  No  Yes

Had sex under the influence of drugs  No  Yes

Shared needles in injection of drugs  No  Yes

Received blood transfusion  No  Yes

Occupational exposure (needlestick/sharps)  No  Yes

## REASONS FOR HIV TESTING

Please check all that apply.

- Possible exposure to HIV
- Recommended by physician/nurse/midwife
- Referred by a peer educator
- Employment - Overseas/Abroad
- Employment - Local/Philippines
- Received a text message/email encouraging me to get an HIV test
- Requirement for insurance
- Other (please specify): \_\_\_\_\_

## PREVIOUS HIV TEST

Have you ever been tested for HIV before?  No  Yes. Date of most recent test? / /

Which HTS provider (facility or organization) conducted the test? \_\_\_\_\_ City/Municipality: \_\_\_\_\_

What was the result?  Reactive  Non-reactive  Indeterminate  Was not able to get result

## To be filled out by HTS PROVIDER only

## MEDICAL HISTORY & CLINICAL PICTURE

Please check all that apply.

- Current TB patient
- With hepatitis B
- Diagnosed with other STIs
- With hepatitis C
- Taken PEP
- Taking PrEP

Clinical Picture:  Asymptomatic  Symptomatic Describe S/Sx: \_\_\_\_\_

World Health Organization (WHO) Staging: \_\_\_\_\_  No physician to do staging

## TESTING DETAILS

Client type: (select one)  Inpatient  Walk-in/outpatient  Persons Deprived of Liberty (PDL)  Mobile HTS / Outreach in physical venues. Specify venue: \_\_\_\_\_

Mode of reach: (select all that apply)  Clinical reach  Online  Index testing  Social and sexual network testing  Outreach in physical venues

Refused HIV Testing Reason for refusal: \_\_\_\_\_

Accepted HIV Testing

HIV testing modality:  Facility-based testing (FBT)  Non-laboratory FBT  Community-based  Self-testing

Linkage: (choose all that apply)  Refer to ART  Advise for re-testing in \_\_\_\_\_ Months \_\_\_\_\_ Weeks

Refer for Confirmatory Suggested date: (MM/DD/YYYY) \_\_\_\_\_

Other services provided to client:

- HIV 101
- IEC materials
- Risk reduction planning
- Referred to PrEP or had given PEP
- Other services: \_\_\_\_\_
- Condoms, # distributed: \_\_\_\_\_
- Lubricants, # distributed: \_\_\_\_\_
- Offered social and sexual network testing (SSNT)
- Accepted SSNT

### Inventory Information

Brand of test kit used: \_\_\_\_\_

Number of test kit used: \_\_\_\_\_

Test kit lot number: \_\_\_\_\_

Expiration date (mm/dd/yyyy): \_\_\_\_\_

## HTS PROVIDER DETAILS

Name of Testing Facility/Organization: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Contact Numbers: \_\_\_\_\_ Email address: \_\_\_\_\_

Primary HTS provider: (select one)  HIV Counsellor  Medical Technologist  CBS Motivator  Others: \_\_\_\_\_

Name & Signature of service provider: \_\_\_\_\_

END