



COUNSELING ASSESSMENT FOR HIV TESTING

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 58941 (4-09)

This form should be used as a guide by the counselor when testing clients for HIV.

Date

Client Information

Last Name	First Name	Date of Birth
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Pre-Test Counseling Assessment

Explanation of Testing

- Discuss confidentiality issues.
- Explain what a negative test result means.
- Explain what a positive test result means.
- Informed consent for testing signed and dated.
- Appointment for results scheduled for (date) _____.
- Assess and discuss client's risk factors for HIV infection.
- Assess client's intention to reduce/modify risky behavior or initiate/increase healthy behavior.

Testing Device

- Venipuncture Site _____
- OraSure _____
- Clearview Complete _____
- Hepatitis Screened
 - IDU MSM Partner of IDU
- Hepatitis Test Venipuncture Site _____
- Provided Counseling for Hepatitis C

Safer Sex and Educational Materials Distributed

- OraSure Handout Condom User Guide
- Clearview Complete Handout
- HIV Testing Brochure Condoms
- HIV Facts Brochure Female Condoms
- HIV/AIDS Transmission Safer Sex Kit
- STD Facts Dental Dam
- Other Other

Risk Reduction Plan

- Explain purpose of a risk reduction plan.
- Confirm with client plan is realistic and feasible.
- Identify and discuss previous prevention failures.
- Discuss barriers to safer behavior.
- Reinforce and support positive prevention choices.
- Safer goal behaviors and action plan given to client.

Options Available for Reducing Risk of HIV

- Monogamous Relationship
- Limiting Sexual Partners
- Consistent Usage of Condoms
- Avoid Sharing Needles/Drug Paraphernalia
- Demonstration of Condom Usage
- Use of Condoms/Dental Dams for Oral Sex
- Condoms Offered

Post-Test Counseling Assessment

Test Result <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive	Date
Copy of test results given to client? <input type="checkbox"/> Yes Date Given _____ <input type="checkbox"/> No Why? _____	

Negative Test Results

<input type="checkbox"/> Explain the validity of a negative result.	<input type="checkbox"/> Review strategies for risk reduction.
<input type="checkbox"/> Recommendation to retest in 3-6 months, depending on risk.	<input type="checkbox"/> Review resources for support, treatment, & counseling.
<input type="checkbox"/> Address any questions related to the test.	<input type="checkbox"/> Provide referrals if necessary.
<input type="checkbox"/> Review assessment of risk factors from pre-counseling.	

If the Clearview® Complete rapid test is preliminary positive (reactive) please submit a confirmatory test to the State Lab and provide the following information to the HIV Program.

HIV Confirmation Test (OraSure® or Clearview® Complete Preliminary Positive)

<input type="checkbox"/> Venipuncture Site _____
<input type="checkbox"/> Scheduled return for results _____
<input type="checkbox"/> Notified the HIV/AIDS Program Date _____ Personnel _____
<input type="checkbox"/> Fax a copy of the preliminary positive test result to the HIV Program, confidential fax at 701.328.0356

Positive Test Results (OraSure® or Clearview® Complete Positive and Confirmatory Positive)

<input type="checkbox"/> Assess client's readiness to receive results.	Provide appropriate referrals:
<input type="checkbox"/> Explain the meaning and validity of a positive test.	<input type="checkbox"/> Medical evaluation with: _____
<input type="checkbox"/> Address any questions related to test results.	<input type="checkbox"/> TB Testing
<input type="checkbox"/> Client to notify sexual/drug contacts.	<input type="checkbox"/> STD Testing
<input type="checkbox"/> Review risk reduction plan.	<input type="checkbox"/> Hepatitis Testing/Vaccination
<input type="checkbox"/> Notified the HIV/AIDS Program Date _____ Personnel _____	<input type="checkbox"/> Mental Health
	<input type="checkbox"/> ND CARE Program
	<input type="checkbox"/> CAP Case Management

Notes

Counselor's Signature

_____	_____
Name	Date