REASON FOR HIV TEST

15 **Reason for HIV Testing: (check all that apply)**

- ☐ Mother is infected with HIV
- ☐ Sex partner is infected with HIV
- ☐ Shared needles/syringes with IDUs
- ☐ Accidental needle prick
- ☐ Recommended by physician
- ☐ Requirement for insurance
- ☐ Received blood transfusion
- ☐ Re-check previous HIV test result
- ☐ Employment - Local/In the Philippines
- ☐ Employment - Overseas/Abroad
- ☐ Pregnant
- ☐ TB patient
- ☐ Active Hepatitis B/C
- ☐ No particular reason
- ☐ Other (pls specify): _____

HISTORY OF EXPOSURE

16 **Was your birth MOTHER infected with HIV when you were born?** ☐ No ☐ Yes

17 ***Answer all*. Have you experienced any of the following?** (If yes, state the MOST RECENT year)

Received blood transfusion	☐ No	☐ Yes	If yes, what year: _____
Injected drugs without doctor's advice	☐ No	☐ Yes	If yes, what year: _____
Accidental needle prick	☐ No	☐ Yes	If yes, what year: _____
Sexually transmitted infections (STI)	☐ No	☐ Yes	If yes, what year: _____
Sex with a female with no condom	☐ No	☐ Yes	If yes, what year: _____
Sex with a male with no condom	☐ No	☐ Yes	If yes, what year: _____
Sex with a person in prostitution	☐ No	☐ Yes	If yes, what year: _____
Regularly accept payment for sex	☐ No	☐ Yes	If yes, what year: _____

SEXUAL PARTNERS

18 ***Answer both*. If none, write "0" in the box.**

How many FEMALE sex partners have you ever had? ☐☐☐☐☐ Year of last sex with a female: _____

How many MALE sex partners have you ever had? ☐☐☐☐☐ Year of last sex with a male: _____

HIV TESTING

19 **Have you ever been tested for HIV before?** ☐ No ☐ Yes

If yes, when was the most recent test? ☐☐ Month ☐☐☐☐ Year

Which testing facility did you have the test? _____ Municipality/City: _____

What was the result? ☐ Positive ☐ Negative

To be filled up by PHYSICIAN, CLINIC STAFF or COUNSELOR only

20 **Clinical Picture:** ☐ Asymptomatic ☐ Symptomatic Describe S/Sx: _____

World Health Organization (WHO) Staging: _____ ☐ No physician available to do staging

To be filled up by TESTING FACILITY only

21 **Name of Testing Facility:** _____

HIV EQAS Lab Code: _____ **Year last participated in HIV EQAS:** _____

Complete Mailing Address: _____

Contact Numbers: _____ **Email address:** _____

22 **Name of Medical Technologist:** _____

HIV Proficiency Number: _____

Date Issued: ☐☐ Month ☐☐ Day ☐☐☐☐ Year **Expiration Date:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

23 **Name of Counselor (with signature):** _____

To be filled up by SACCL only

24 **SACCL Laboratory Code:** ☐☐☐☐☐☐☐☐☐☐ **Date HIV Confirmed:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

HIV Results Confirmed by: _____ **Test:** ☐ Western Blot ☐ PCR for infants

END