D H E C

PROMOTE PROTECT PROSPER

Testing and Treatment History Questionnaire

1. Date Information collected: -------/-------/------- Patient Name: _____

2. Main source of Testing and Treatment History Information (Select one):

☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐PEMS ☐Other

3. Ever had a previous positive test? ☐ Yes ☐ No ☐ Refused ☐Don't know/Unknown

3a. Date of FIRST Positive HIV test: ---------/---------/-------- ☐ Refused

4. Ever had a negative test? ☐ Yes ☐ No ☐ Refused ☐ Don't know/Unknown

4a. Date of LAST negative test: ----------/---------/---------- ☐ Refused

5. Number of negative HIV tests within 24 months before first positive test (count 24 months from the date in question 3a): My first positive test + ------ # of negative tests [ ][ ] ☐ Refused ☐Don't know/Unknown

(Add +1 to number of negative tests until conversion to eHARS after conversion stop adding 1)

Medicine History

6. Have you ever taken any Antiretroviral (ARVs) medications (use colored chart to show list of Medications to the patient) to treat or try to prevent HIV or Hepatitis?

☐ Yes ☐ No ☐ Refused ☐ Don't know/Unknown

If NO, STOP, you are done with the questionnaire. If YES, Please answer the following.

6a. Which ARV medications did you take? _____

6b. What date did you FIRST take ARVs? ----------/---------/----------(month/day/year) ☐ Refused

6c. What date did you LAST take ARVs? ----------/---------/---------- (month/day/year) ☐ Refused

6d. Are you currently taking these medicines? ☐ Yes ☐ No ☐ Refused ☐ Don't know/Unknown

Person Completing this form please write your name below:

_____

Within 30 days, please return to:

Samira Khan
SC DHEC
Incidence & Resistance Surveillance Coordinator
1751 Calhoun St. 3rd Floor
Columbia, SC 29201

Please complete this form for:
Only Newly Diagnosed HIV clients
> 13 years old

Title of Form: Testing and Treatment History Questionnaire- DHEC 1314

Purpose of the form: This form will be completed by the client who has tested positive for HIV for the first time in the past three months. The purpose of this questionnaire is to collect data for HIV Incidence Surveillance (HIS).

Who will complete the form: Staff in STD/HIV clinics conducting Post Test Counseling will complete this form. If this form is not completed at the time of Post Test Counseling, the Disease Intervention Specialists will complete this form at the time of the HIV Interview Record. If a satisfactory completion rate is not achieved then an Area Surveillance Coordinator may be involved to gather information. Any one completing this form will be conducting a surveillance activity.

Item-by-item instructions for completing the form:

- # 1 – Date information was collected by the staff
- # 2 – Main Source of Information: Client Interview, Provider Report or Medical Record Review, PEMS, Other
- # 3 – Ever had a Previous positive HIV test: Yes, No, Refused, Don't Know/Unknown
- 3a – If client report "YES" to # 3 then collect - Date of FIRST Positive HIV Test- Earliest date of a positive test results reported by patient.
- 4 – Ever had a Negative HIV test – Patient self Report: Yes, No, Refused, Don't Know/Unknown
- # 4a – IF "YES" to #4 – Record date of most recent known negative test result, even if more recent test with unknown result exists.
- #5 – Number of Negative HIV tests Within 24 Months Before First Positive Test: #---------, Refused, Don't know/ Unknown
- # 6 – Ever taken Any Antiretroviral (ARV) – show list of ARV to client- if client is unsure of forgot names of ARV: Yes, No, Refused, Don't Know/Unknown
- # 6a – Names of ARV medications: show list of ARV to client- if client is unsure of forgot names of ARV
- # 6b – Dates ARV Medications taken- Date FIRST Began
- # 6c – Dates ARV Medications taken- Date of LAST Use
- # 6d – Are you currently taking these medicines? Yes, No, Refused, Don't Know/Unknown

Office mechanics and filing: This form will be sent to DHEC Central Office HIV Surveillance staff to be entered into the Incidence and Viral Resistance (IVR) Database. It will not be stored in the patient clinical record; a paper copy of the form will be kept for 90 days in a secure file room after data entry into the IVR database. After 90 days paper copies of the forms will be shredded, using cross-cut shredder. The data will be stored indefinitely in electronic format.