Request for HIV Confirmatory testing from the Reference Laboratory of the National STD/AIDS Control Programme

(VERSION: 7.4.2017)

Instructions: To be completed by referring doctor/healthcare worker at the time of requesting HIV Confirmatory test from the reference laboratory of the National STD/AIDS Control Programme, No. 29, De Saram Place, Colombo 10, Sri Lanka. Patient should be informed that all questions contained in this questionnaire are strictly confidential and will become part of their medical record? PART II - TESTING DETAILS AND DEMOGRAPHIC INFORMATION FART III - TESTING DETAILS AND DEMOGRAPHIC INFORMATION ISTO chilc patient INFORMATION ISTO chilc patient INFORMATION ISTO chilc patient INFORMATION A. STO Chilc Registration Number Candler Sequential Mo Year Clinic Code INFORMATION ISTO chilc patient INFORMATION A. Has patient/client ever been tested for HIV previously INITISTING INFORMATION INFORMATION INFORMATION S. Name and address of Patient/Client Address:						
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HIV SCREENING TEST DETAILS b. Particle Agglutination Test				5. Date of Screening Test.	_	
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d. Other		☐ b. Particle A	gglutination Test	Day Month Year		
4. Has patient/client ever been tested for HIV previously		☐ c. Rapid Dia	gnostic Test			
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Address		4. Has patient/client ever been tested for HIV previously				
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14. Clinical status at the time of diagnosis/testing □ a. Asymptomatic □ b. Symptomatic HIV □ c. AIDS						
PART III:INFORMATION ON EXPOSURE TO HIV 15. Sexual Exposure (Multiple Responses Possible	16. Ever sold sex to clients					
☐ a. Sexual Contact with Regular Partner of Opposite Sex	□ a. Yes					
☐ b. Sexual Contact with Non-Regular Partner of Opposite Sex	□ b. No					
☐ c. Sexual Contact with Person of Same Sex						
☐ d. Sexual Contact with Both Sexes						
☐ e. No Sexual Contact						
17. Ever bought sex from a sex worker	18. Ever gone abroad?					
☐ a. Yes	a. Yes, countries:					
☐ b. No	☐ b. No					
19. Ever had sex with a foreigner? (In Sri Lanka or abroad)	20. History of Blood Exposure					
	a. No					
a. Yes	☐ b. Injecting Drug Use					
□ b. No						
c. Not Applicable (Foreign Nationality)	c. Receipt of Blood/Tissue/Organ/Sperm					
	d. Needle stick injury/mucosal splash Specify year:					
21. Acquired from mother to child transmission						
☐ a. No						
□ b. Yes						
☐ c. Not Known						
INFORMATION ABOUT SPOUSE/LIVE-IN PARTNER E						
22. HIV status of spouse	23. Has spouse ever gone abroad?					
a. Positive	a. Yes, countries					
☐ b. Negative	□ b. No					
☐ c. Not Known	c. Not Known					
d. Not Applicable	d. Not Applicable					
24. Risk factors for HIV in spouse						
a. None b. MSM c. Sex Worker (now or former) d. Multiple Sex Partners						
☐ e. Injecting drug user (now or former) ☐ f. Not Known ☐ g. Not Applicable						
DETAILS OF THE REFEREING DOCTOR/HEALTHCARE WORKER						
A. Name :	D. Institution :					
	E. Telephone No.:					
B. Signature :						
C. Designation:	F. Date :					