Attachment 1 (submit to SHP prior to beginning HIV testing and as needed for updates)

HIV Prevention Counseling, Testing and Referral (CTR)
Site Registration Form

All sites, whether fixed or mobile, must be registered with OPH SHP.
Please allow two (2) weeks for processing.

Type of Request (check one): □ **New Site** □ **Update Existing Site** □ **Drop Site**

Contact Information (Agency Conducting HIV Testing):

Agency:_____ Site#:_____

Contact Person/Title:_____

Mailing Address: _____

City, State, Zip: _____

OPH Region: _____ Parish:_____

Phone Number:_____ Fax Number:_____

E-Mail Address:_____ CLIA Certificate #:_____

Site Information (physical location where HIV Testing will be conducted):

Name of Site: _____

Site Address: _____

City, State, Zip: _____

Description of Site Type: _____

Description of Test Set-Up:_____

Phone Number:_____ Fax Number:_____

Type of Testing Requested (check all that apply):

□ Rapid Testing:_____ □ OraSure □ Blood (lab)

Return completed form to SHP Testing Supervisor

For Office Use Only: Date request received:_____ Date visited:_____

Recommendation:_____

Approved for: □ Rapid Testing:_____ □ OraSure □ Blood (lab)

Site #:_____ **Parent Site #:**_____ **Site Type:**_____

CTR Supervisor's Initials:_____ Approval Date: _____

Attachment 2 (submit to SHP as needed)

Quality Assurance Coordinator
Registration/Designation Form

All sites conducting HIV Testing supported by SHP must designate and register a Quality Assurance Coordinator. The Quality Assurance Coordinator should be a person fully trained on conducting all HIV testing methods used at his/her site and be responsible for the overall quality of HIV testing including monitoring storage and handling conditions of supplies and the competency of testing staff.

Submit to SHP immediately whenever the designated Quality Assurance Coordinator changes or when updates/changes to his/her contact information occur.

Rapid Testing Site:_____Site Number:_____

Date Form Submitted:_____Submitter:_____

Reason for Submission:

____Newly Designated Quality Assurance Coordinator
____Change in Quality Assurance Coordinator's contact information
____Other, specify below:

_____
_____
_____

About the Designated Quality Assurance Coordinator:

Name*: _____
Title*: _____
Work Address*: _____
_____
_____
Counselor Number*: _____
Work Phone*: (____)_____
Cell: (____)_____
Alternate Phone (____)_____
Work Email*: _____
Alternate Email: _____

Number of Months/Years Experience with Rapid Testing:_____

***Areas marked with an asterisk are required fields**

Fax completed form to (504) 568-7044
Attention CTR Supervisor

Attachment 3 (maintain on-site)

HIV Testing Device Temperature Log

Testing Site: _____ City: _____

Testing Kits Location:_____

Type of Rapid Test Kits: □ **OraQuick** □ **Uni-Gold** □ **Clearview** □ **INSTI**

The high and low temperatures of the test kit storage area should be recorded using a digital thermometer with a temperature range memory that will display the warmest and coolest temperatures reached in the storage area in-between checks.

If temperature falls outside the allowable range, notify quality assurance coordinator immediately.

Allowable Temp Range:	from: _____degrees C/F	to: _____degrees C/F

Daily Temperature Record for Month:_____Year:_____

Date	Low	High	Initial	Date	Low	High	Initial
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			
				31			

Note any incidents and corrective actions taken below:

	Corrective Action
Date:	

Quality Assurance Coordinator_____ Date:_____

Attachment 4 (maintain on-site)

Control Kit Temperature Log

Testing Site: _____ City: _____

Control Kits location:_____

Type of Rapid Test Control Kits: □ **OraQuick** □ **Uni-Gold** □ **Clearview** □ **INSTI**

The high and low temperatures of the control kit storage refrigerator should be recorded using a digital thermometer with a temperature range memory that will display the warmest and coolest temperatures reached in the refrigerator in between checks.

If temperature falls outside the allowable range, notify quality assurance coordinator immediately.

Allowable Temp Range:	from: ____ degrees C/F	to: _____degrees C/F

Daily Temperature Record for Month:_____Year:_____

Date	Low	High	Initial	Date	Low	High	Initial
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			
				31			

Note any incidents and corrective actions taken below:

	Corrective Action
date:	

Note: Control kits expire _____ after opened (same as expiration date printed on the package for Clearview Stat Pack controls).

Quality Assurance Coordinator_____ Date:_____

Attachment 5 (maintain on-site)

Daily Rapid HIV Test Log

(If using multiple rapid testing technologies, use a separate log for each type of rapid testing device)

Test Site:_____ Date of Testing:_____

Type of Rapid Test: □ OraQuick □ Uni-Gold □ Clearview □ INSTI
(use a separate form for each different type of test used)

Tester #	Test Form Number or Label	Room Temperature	Time Test Started	Time Test Result Read	Rapid Test Result	Date Client Notified	Lot Number of Test Kit	Test Kit Expiration Date
					□ Reactive □ Neg □ Invalid □ No result			
					□ Reactive □ Neg □ Invalid □ No result			
					□ Reactive □ Neg □ Invalid □ No result			
					□ Reactive □ Neg □ Invalid □ No result			
					□ Reactive □ Neg □ Invalid □ No result			
					□ Reactive □ Neg □ Invalid □ No result			

Quality Assurance Coordinator:_____ Date:_____

Attachment 6 (maintain on site)

Control Kit Log

(If using multiple rapid testing technologies, use a separate log for each type of rapid testing device)

Test Site:____ **Month/Year:**________________________

Control Kit Lot #:__________________________ **Manufacturer's Expiration Date:**______________

Date Kits Opened:__________________________ **Control kits are good for:**_____ ____ _____**after opening*.**

Type of Kit Controls: ☐ **OraQuick** ☐ **Uni-Gold** ☐ **Clearview** ☐ **INSTI**

Date	Tester #	NEG	HIV-1	HIV-2 (if applicable)	Reason for running controls
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	
		☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	

***same as expiration date printed on the package for Clearview Complete controls**

Quality Assurance Coordinator:____ Date:_____________

Attachment 7 (submit to SHP monthly)

HEALTHCARE SITES HIV TESTING SUPPLY ORDER FORM

Contact Information (Agency conducting HIV Testing):

Testing Site Name:_____ Order Date:_____

Quality Assurance Coordinator:_____

Mailing Address: _____

City, State, Zip: _____ Phone Number: _____

Fax Number:_____ E-Mail Address:_____

Please write the number of cases/boxes/packets needed. Please allow a minimum of 4 weeks for delivery or pick up. Some items may not be available at the time of order or available to your site.

LIST OF SUPPLIES	QUANTITY	# ORDERED	For SHP Use
HIV Test Form – Part 1 (HIV 10)	100 forms/packet		
Sites must have prior approval from OPH SHP before ordering any of the following items:			
OraQuick ADVANCE Rapid Test Kits	100 kits/box		
OraQuick ADVANCE Kit Control	1 kit/box		
Uni-Gold Recombigen Rapid Test Kits	20 kits/box		
Uni-Gold Kit Control	1 kit/box		
Clearview Complete Rapid Test Kits	20 kits/box		
Clearview Kit Control	1 kit/box		
INSTI Rapid Test Kits	50 kits/box		
INSTI Kit Control	1 kit/box		
Digital Memory Thermometer	Each		
Timer	Each		
Workspace Covers	100/box		

Fax this completed form to:

ATTENTION SHP PURCHASING & SUPPLIES COORDINATOR

Fax number: (504) 568-7044

For SHP Use Only:

SHP Staff Initials:_____ Date received:_____

Rapid Tests Lot #: _____ Rapid Tests expiration date:_____

Control Lot #:_____ Control kit expiration date:_____

ORASURE Lot #:_____ ORASURE expiration date:_____

Delivered to (name):_____ Date delivered: _____

Delivered to (name):_____ Date delivered:_____

Attachment 8 (submit as occurs)

Discordant Test Case Report

This form is to be completed for ALL testing situations that involve a Preliminary Positive/Reactive rapid HIV test result and an *Indeterminate* or *Negative* Western blot or IFA test result. **Submit to SHP immediately when a test is recorded as Discordant.**

If the Western blot or IFA confirmatory test result is negative or indeterminate, REPEAT a confirmatory test on a new blood specimen collected four (4) weeks after the initial preliminary positive result.

Site Information

Site Name:_____ **Site City:**_____

Tester:_____ **Tester#:**_____

Telephone #:_____ **E-mail Address:**_____

Client Information

HIV Test Form #:_____

Client ever previously tested? □ Yes □ No **Client ever tested positive?** □ Yes □ No

Contact information obtained? □ Yes □ No

Vaccination History:

Hepatitis A? □ Yes □ No □ Unknown Dose 1 Year:_____Dose 2 Year:_____

Hepatitis B? □ Yes □ No □ Unknown Dose 1 Year:_____Dose 2 Year:_____Dose 3 Year:_____

Initial Rapid HIV Test Device: □ **OraQuick** □ **Uni-Gold** □ **Clearview** □ **INSTI**

Test Type: □ Confidential □ Anonymous □ Unknown **Specimen Type:** □ Blood □ Oral Fluid □ Other

Date of reactive rapid test:_____/_____/_____ **Lot #:**_____
MM DD YEAR

Test Start Time:___:_____ AM/ PM **Test Read Time**:_____:_____ AM/ PM

Repeat Test Device (if applicable) □ **OraQuick** □ **Uni-Gold** □ **Clearview** □ **INSTI**

Repeat Rapid Test Conducted? □Yes □ No **If yes, Lot #:**_____

Test Start Time:___:_____ AM/ PM **Test Read Time:**_____:_____ AM/ PM

Repeat Test Result: □ Reactive (Preliminary Positive) □ Negative □ Invalid

Follow-up Blood Test:

HIV Test Form#:_____

Date of Follow-up test: _____/_____/_____ Western Blot or IFA Result: _____
MM DD YEAR

Client/Patient Received Follow-up Test Result? □Yes □ No If yes, Date Results Received:_____

If no, why:_____

Quality Assurance Coordinator:_____ Date:_____

Attachment 9 (maintain on site for each testing staff)

HIV Testing Competency Assessment for Health Care Testing Staff

Testing Site:_____ **Assessment Date:**_____

Testing Staff's Name:_____ **Testing Staff's ID#:**_____

Type of Rapid Test: □ **OraQuick** □ **Uni-Gold** □ **Clearview** □ **INSTI**
(use a separate form for each different type of test used by each testing staff)

Procedure	Satisfactory	Unsatisfactory	Not Applicable	Comments
Part 1: Communication and Test Processing with Patients				
Communication to Patient before testing (see protocol)				
Patient Preparation for Test				
Specimen Handling				
Test Processing (see during testing in protocol)				
Communicating Test Results				
Documenting Test Results				
Communicating to Patient after testing (see protocol)				
Disposal of Infectious Waste				
Part 2: Running Controls and Quality Assurance Documentation				
Test Processing with Known Specimens (Controls)				
Interpretation of Control Test Results				
Disposal of Infectious Waste				
Documentation of Control Test Results				
Review of Temperature Control Logs				
Assessment of Problem Solving Skills				

Evaluator's Name:_____ **Evaluator's Title:**_____

Evaluator's Signature:_____ **Date:**_____