Annex I-A HTS Counselling Form

National HIV, AIDS & STI Prevention and Control Program
HIV Testing Services (HTS) Form 1
HIV Test Counseling Form

Clients Name:_____ Birthdate: __ __/__ __/__ __
(M M/ D D/ Y Y)

UIC : __ __|__ __|__ __|__ __|__ __|__ __ __ __

UIC: First two letters of mother's name, first two letters of father's name, two-digit birth order, birthdate (MM-DD-YYYY)

PRE-TEST counselling interventions: Date of Pretest Counseling: _____	**Client's Contact Details:**
Confidentiality and privacy offered to the client Basic information about HIV Basic information about the test and result provision procedure **Any other special needs expressed by the client** Informed consent to undergo HIV test obtained Others:_____	*I am allowing the counsellor to use all means of communication provided here to contact me when my test result is available.* **Phone no**:_____ **Email add.**: _____ **Others:** _____

Informed Consent	
I was given information about HIV, HIV testing process and was given the opportunity to ask questions. **I agree to undergo HIV Testing.**	Client's Signature: _____ Client's Name: --- Date: __ __/__ __/__ __ (M M/ D D/ Y Y)

POST TEST Counselling: **It is an ethical obligation of the HIV counselor to check the test result if it is consistent with the label on the envelope and with that of the identified client before giving the official copy of the test result.**

☑ *Please check the box if the following are performed.*

For NEGATIVE Screening / Confirmatory Test	Schedule for Retest	
Latest or ongoing significant risk Risk reduction planning Condoms and lubricants Referral for continuous support, STI & HIV prevention services	Annual After six (6) weeks Others:	Date (mm/dd/yy): __ __/__ __/__ __ __ __/__ __/__ __ __ __/__ __/__ __

HIV Screening REACTIVE	HIV POSITIVE
Risk reduction planning STI, Hep B, HIV prevention messages Condoms and lubricants Referral to treatment hub for early assessment	Assessment for risk for suicide / self-harm / violence to others Immediate support for client Risk reduction planning STI, Hep B, HIV prevention messages Condoms and lubricants ART Initiation, OI management Disclosure to partner(s)/family Partner(s) / children for HIV Testing Other Referral needs **Consent for Release of Information** Other Interventions: _____

Remarks (use back side for additional notes):

_____

_____

Name & Signature of Counselor: _____ Date: __ __/__ __/__ __
(M M/ D D/ Y Y)

Name of Facility: _____

Request Client to complete the Client Satisfaction Form (HTS Form 4)

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