

INSTRUCTIONS for HIV TESTING REPORT FORM (DHHS 1111) and HIV/HCV TESTING REPORT FORM (DHHS T1535)

General Instructions

Purpose: The **DHHS 1111** form is to be completed for all patients who undergo HIV testing events only. Use the **DHHS T1535** form for patients who undergo HIV and/or HCV testing events. **Do not complete forms for patients who decline testing.**

Teleform: The NC State Laboratory of Public Health (SLPH) uses Teleform to scan and process this form. This technology requires flat, clean forms that are easy and legible for the computer to read. **DO NOT USE PHOTO COPIES.** If you need additional copies of the submission form, print them from the original PDF provided to you or you may call the Virology/Serology Unit office at 919-733-7544 to have an electronic copy emailed to you.

A data entry person must manually verify any letters or numbers that the computer cannot interpret. Please help us to save time and improve accuracy by writing carefully and following the instructions below. Use X instead of ✓ for check boxes. Do not mark outside of the boxes with any stray marks.

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. Follow the sample letters and numbers as closely as possible.	A	B	C	D	E	F	G	H	I	J	K	L	M
	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
	1	2	3	4	5	6	7	8	9	0			

Field Level Instructions

Check if No SLPH Test Requested: Please mark if you are sending the completed form to the SLPH for data reporting purposes ONLY and are NOT submitting a sample to be tested. **This box must be checked for Rapid Testing Only forms.**

Test Requested: For **DHHS 1111**, please mark the box to indicate that you are requesting an HIV test be performed on the sample. For **DHHS T1535**, mark the box to indicate that you are either requesting an HIV, an HCV test, or both tests be performed on the sample. **For Rapid Testing Only forms, leave boxes unchecked.**

Printed Label: Agencies may use printed labels in lieu of filling out certain patient information. **Rapid Testing Only agencies may not use labels.** The standard Patient Information Label/HSIS Laboratory Label format is available from Virology/Serology. Please align the label in the box on the top right of the form. The label must fit within the box, not touch the lines on the edge of the box, and the printed information must be parallel to the top of the box. Labels placed at an angle will not be read accurately.

Patient Information: Complete the information if the standard label/HSIS Laboratory Label is not attached. All information is required unless otherwise indicated.

- Patient/Client Last Name, First Name, Middle Initial.
- Address – patient/client’s residence – 1st line for house number, street name, etc.; 2nd line for apt, suite, etc. *This information is for surveillance/contact purposes only and is not required for complete data entry.*
- City – patient/client’s city of residence.
- County – patient/client’s county of residence. *North Carolina 3-digit numeric county code (001-100). Use 101 for counties outside of NC.*
- State – patient/client’s state of residence. *Alpha state abbreviation, i.e. NC for North Carolina.*
- Zip Code – patient/client’s zip code of residence.

INSTRUCTIONS for HIV TESTING REPORT FORM (DHHS 1111) and HIV/HCV TESTING REPORT FORM (DHHS T1535)

- Local Pt ID – Patient/Client ID defined for local use, i.e. chart number. *This information is for use by your agency and is not required for complete data entry. It may be used in place of SSN as a unique identifier for sample identification purposes.*
- SSN – Social Security Number of the patient/client. *This information is not required for complete data entry, but may be used as a unique identifier for sample identification purposes.*
- Date of Birth – Month/Day/Year (use a 4-digit year).
- Medicaid Client – Mark YES box if patient/client is on Medicaid. If patient is unsure, look up Medicaid eligibility if possible before completing. *This information is used for billing purposes and will not negatively affect the patient/client's coverage. If the client does not want to supply their Medicaid eligibility information, it is not required for complete data entry.*
- Medicaid ID – Medicaid ID number on patient/client's Medicaid card. Look up Medicaid number if patient/client does not have the card. *This information is used for billing purposes and will not negatively affect the patient/client's coverage. If the client does not want to supply their Medicaid ID number, it is not required for complete data entry.*
- Annual Exam Date – For Family Planning patients only; Month/Day/Year (use a 4-digit year).
- Dx. Code/ICD – (ICD10).
- Race – Mark all that apply.
- Ethnicity – Mark one box.
- Gender – Mark one box.
- If Female, Is Patient/Client Pregnant – mark yes, no, or unknown.

Agency: Please complete the information based on the submitting agency.

- EIN Number – Employment Identification Number with the **NC SLPH assigned suffix for specific sites.**
- Agency Name – please complete your agency's name as provided to you. Do not add any additional identification information to this section.
- Program Code – Choose the code that best matches your program area. If you are funded by the state, choose ITTS, SAC, ET, EBIS, or CAPUS as applicable. If you are not funded by the state but receive state purchased rapid test kits, choose the RT code. If you are funded by other sources, choose applicable code. Contact your program consultant for assistance.

NOTE: Specific program codes do not apply to routine testing at health departments.

- ITTS – Integrated Targeted Testing Sites
- SAC – Substance Abuse Centers
- PCRS – Partner Counseling and Referral Services
- ET – Expanded Testing
- CAP – Care and Prevention in the United States (CAPUS)
- EBIS – Evidence Based Intervention Services
- RT – Rapid Testing Only
- CDC – CDC Direct Funding
- MH – Minority Health
- HRSA – Health Resources and Service Administration Direct Funding
- OTH – Other Sources Not Indicated
- **NPI Number** – Enter NPI for ordering provider. Do not use NPI assigned to facility.
- **Ordering Provider's Last Name** – Write in last name of provider assigned to NPI number above.

Test Setting: Indicate testing site; please mark only one. Select the option that best describes where the HIV and/or HCV test was performed. For clarification purposes:

- An HIV Testing Site is a dedicated site primarily providing HIV counseling and testing services.

INSTRUCTIONS for HIV TESTING REPORT FORM (DHHS 1111) and HIV/HCV TESTING REPORT FORM (DHHS T1535)

- A Community Setting is testing done in defined areas in which a group of people live, work or congregate, such as schools, churches, shelters, business sites, residential areas, public areas, worksites, etc. Most outreach testing would fall into the community setting category as long as one of the other test settings does not apply.
- Use “other clinical” and “other non-clinical” only as directed by your program consultant.

Risk Factors: For **DHHS T1535**, mark “Current 900” or “History of injection drug use” for clients with lifetime risk factors for HCV. “Current 900” means that the client is known to be HIV positive. **For both forms**, mark all behaviors that apply during the **last 12 months**.

HIV Test Information: For complete data entry, at least one box of this section must be completely filled.

- Previous HIV Test – Mark yes, no, or unknown. Previous testing includes all tests prior to testing event(s) listed below.
- Rapid Tests/Other Lab HIV Tests – If verified, please list up to two most recent HIV tests (including rapid test results if performed this visit).
 - Sample Date – Date rapid or other HIV test was administered. Month/Day/Year (use a 4-digit year).
 - Collector ID – Initials of healthcare worker who performed test.
 - Technology – Mark “Rapid” for rapid tests and mark which Rapid Test Used; if “Other”, fill in brand of rapid test. Mark as applicable for most recent HIV results.
 - Test Result – Mark one box.

Note: For a conventional confirmatory test, fill in the Sample Date as the date of the blood draw, mark “Conventional” in the Technology section, and indicate the test result.

- SLPH Testing – If sample is being submitted to the SLPH for testing, please complete.

Note: Prior approval for sample submission to the SLPH is required.

- Sample Date - Month/Day/Year (use a 4-digit year).
- Collector ID - Initials of healthcare worker who collected the sample.
- Type of Sample - Mark one box.
- Local Use Data Fields – May be used by submitter for local use information.

LAB USE ONLY: PLEASE DO NOT WRITE IN THIS AREA OF THE FORM

Form/Sample Submission Instructions

Mailing Instructions for Rapid Testing Only Programs:

- Send completed DHHS 1111 and DHHS T1535 forms to the SLPH at the address on the top of the form on the 28th day of each month.
- Do not include forms with submitted samples in the same envelope as data entry only forms.
- Forms should be placed flat in a manila envelope with cardboard as these forms will be scanned through Teleform.
- Envelopes should be marked **ATTN: Alisa Alston**.
- Make sure that all envelopes are securely sealed. If using envelopes with a metal bracket, please cover bracket with tape.
- Data forms can be sent via either USPS or FedEx. If FedEx is used, the recipient telephone number should be listed as (919) 733-7834.

Mailing Instructions for forms with samples:

- Completed forms and specimens are to be sent to the SLPH at the address on the top of the form.
- See <http://slph.ncpublichealth.com/> for further sample submission instructions.