Diagnosis Form

This form must be completed and signed by a physician or other licensed healthcare provider. Lab values for initial enrollment must be dated within one year of enrollment. For initial enrollment, please ensure HIV Diagnosis Test Type is identified and CD4 and Viral Load test results are provided.

Client/Patient Information

Name (First, M.I., Last):_____

Date of Birth:_____

Diagnosis Verification

Indicate the type of test used to confirm HIV infection

- ☐ Geenius assay (HIV type differentiating assay)
- ☐ HIV quantitative RNA assay (i.e., HIV viral load test)
- ☐ Indirect Fluorescent Antibody (IFA)
- ☐ Two different positive rapid assays
- ☐ HIV qualitative RNA assay (HIV-1 RNA NAAT)
- ☐ Western blot
- ☐ HIV genotype
- ☐ Other (specify): _____

Pending HIV lab

- ☐ One positive rapid assay pending confirmatory HIV lab test (client will be need to be placed on a 30-day Temporary Access Period by the ADAP Enrollment Worker and must provide confirmatory HIV lab within 30 days)

Lab Values

Absolute CD4 Count:_____ Test Date:_____

HIV Viral Load Test Result:_____ Test Date:_____

HIV Viral Load Test Type:

☐ RT-PCR ☐ bDNA ☐ RNA/DNA/NAAT qualitative ☐ RNA/DNA/NAAT quantitative

Diagnosis

☐ HIV – Not AIDS ☐ AIDS – As defined by the CDC

Licensed Health Care Provider Information

Licensed Healthcare Provider Name:_____

Hospital/ Clinic Name:_____

Hospital/Clinic Address:_____

Phone:_____ Date:_____

Licensed Physician or healthcare provider signature:_____