Revised April 2024

Attachment RT-3.1 (maintain on-site) Complete this form in its entirety

Test Device Temperature Log

Testing Site: _____ City: _____

Testing Kits Location:_____

Type of Rapid Test Kits (Check all that apply):
□ **Determine** □ **Insti** □ **Syphilis Health Check** □ **Rapid HCV** □**Sure Check**

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, and cite the corrective action taken.**

Allowable Temp Range for all test kits:	from: ___ degrees F	to: ___ degrees F

Daily Temperature Record for Month: _____Year: _____
Record temperature for every day that agency is open

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:

Date:	**Corrective Action:**

Quality Assurance Coordinator (Required)_____ Date:_____

Attachment RT-3.2 (maintain on-site) Complete form in its entirety

Control Kit Temperature Log

Testing Site: _____ City: _____

Control Kits location:_____

Type of Rapid Test Controls (Check all that apply):
□ **Determine** □ **Insti** □ **Syphilis Health Check** □ **Rapid HCV** □**Sure Check**

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, and cite the corrective action taken.**

Allowable Temp Range for all Controls in use:	from: ___ degrees F	to: ___ degrees 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:

Date:	Corrective Action:

(Required)
Quality Assurance Coordinator _____ Date:_____

Attachment RT-3.3 (maintain on-site)

Daily Rapid Test Log

Test Site:____________________________ Date of Testing:____________________
(note the lot number from the test kit package, not the outer box or shipment materials)

Types of Rapid Test: Determine (DET), Insti (INS), Syphilis Health Check (SHC), Rapid HCV (ORQ), Sure Check (SC)

Type of Rapid Test	Rapid Lab Counselor#	HIV Test form P-Number	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/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			
						☐ Reactive/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			
						☐ Reactive/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			
						☐ Reactive/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			
						☐ Reactive/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			
						☐ Reactive/Positive ☐ Ag ☐ Ab ☐ Non-Reactive/Negative ☐ Invalid			

(Required) Quality Assurance Coordinator:____ Date:__________________

Attachment RT-3.4 (maintain on site)

Control Kit Log

Test Site:______________________ Month/Year:___________________
Control Lot # (for each test kit control):___________________________________
Manufacturer's Expiration Date (for each test kit control):_________________________
Date Kits Opened (for each test kit control):_________________________________

Type of Kit Controls	Date	Counselor #	NEG	HIV-1	HIV-2	Antigen	SHC+	HCV +	<u>Reason for running controls</u>: (a) Prior to a newly trained counselor conducting testing (b) New test kit lot opened (c) New shipment of test kits (d) Temperature falls out of range for kits or controls (f) Prior to using test kits at remote locations (g) Weekly for non-clinical sites/monthly for clinical sites
			☐ 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	☐ 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	

Type of Kit Controls: Determine, Insti, Syphilis Health Check, Rapid HCV, Sure Check

(Required) Quality Assurance Coordinator:___________________________________ Date: __________________

Attachment 2

Rapid STI Testing Site Assessment and Registration Form

All sites, whether fixed or mobile, must be registered with OPH SHHP.
Please allow four (4) weeks for processing.

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

Contact Information (Agency conducting testing):

Agency:_____

Mailing Address: _____

City, State, Zip: _____

OPH Region: _____ Parish:_____

Phone Number:_____ Fax Number:_____

E-Mail Address:_____ CLIA Certificate #:_____

What is the AGENCY ID that this site will be listed under? _____

Executive Director Information:

Name:_____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Executive Director's Email: _____

Prevention Manager Information:

Name:_____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Prevention Manager's Email:_____

Quality Assurance Coordinator Information:

Name:_____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Quality Assurance Coordinator's Email:_____

Site Information (location where CTR will be conducted):

Name of Site: _____

Site Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Detailed Description of Site Type (i.e. clientele, hours of operation, services offered): _____

_____

_____

Detailed Description of Test Set-Up(i.e. how will confidentiality be assured, where in the building will testing happen, etc: _____

_____

Type of Testing Requested (check all that apply):

Rapid Testing:_____ Blood (lab)

(To be completed by Regional Coordinator and submitted as needed)

Date: _____ Observed by: _____

Check appropriate assessment of testing site:

Work space to process test:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Confidential setting:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Cleanliness:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Lighting:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Temperature control:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Supply storage:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Hand washing station:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Record keeping:	□ Acceptable	□ Conditional (describe)	□ Unacceptable
Waiting area:	□ Acceptable	□ Conditional (describe)	□ Unacceptable

Notations:_____

_____

_____

_____

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

Recommendation:_____

SHP Coordinator Initials: _____ CTR Supervisor's Initials:_____ Date logged into database:_____

Approved for: □ HIV Rapid Testing: Primary Test_____ Second Test_____

□ SHC □ HCV □ Whole Blood (lab) **Site #:_____Parent Site #:_____**

Summary (For SHHP Database Entry)

Agency ID _____

Site Name _____

Site Type _____

Type of Test Used _____

Site Street Address _____

Site City _____

Site Zip Code _____

QA Coordinator _____

QA Phone number _____

QA Email _____

Site Region _____

Site Parish _____

Site Types

F01.01 Clinical - Inpatient hospital
F02.12 Clinical - TB clinic
F02.19 Clinical - Substance abuse treatment facility
F02.51 Clinical - Community health center
F03 Clinical - Emergency department
F04.05 Non-clinical - HIV testing site
F06.02 Non-clinical - Community setting - School/educational facility
F06.03 Non-clinical - Community setting - Church/mosque/synagogue/temple
F06.04 Non-clinical - Community Setting - Shelter/transitional housing
F06.05 Non-clinical - Community setting - Commercial facility
F06.07 Non-clinical - Community setting - Bar/club/adult entertainment
F06.08 Non-clinical - Community setting - Public area
F06.12 Non-clinical - Community setting – Individual residence
F06.88 Non-clinical - Community setting - Other
F07 Non-clinical - Correctional facility - Non-healthcare
F08 Clinical - Primary care clinic (other than CHC)
F09 Clinical - Pharmacy or other retail-based clinic
F10 Clinical - STD clinic
F11 Clinical - Dental clinic
F12 Clinical - Correctional facility clinic
F13 Clinical – Other
F14 Non-clinical - Health department - field visit
F15 Non-clinical - Community Setting - Syringe exchange program
F40 Mobile Unit

Attachment RT-3.6 (submit to SHHP as needed)

Quality Assurance Coordinator Registration/Designation Form

All Agencies conducting Rapid HIV Testing in Louisiana must designate and register a Quality Assurance Coordinator. The Quality Assurance Coordinator should be a person with significant experience conducting rapid testing (6 months experience and a minimum of 200 rapid tests conducted) and familiar with storage and operating procedures/requirements of the rapid testing device(s) used at their agency.

Submit to SHHP 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:_____

Attachment RT-3.7 (maintain on site – for information only)

Steps to Prevention Counseling and Rapid Testing Certification

Steps for Obtaining a Counselor Number:

1. Attend a combined HIV, Syphilis, and Hepatitis C Prevention Counseling and Rapid Testing course in its entirety and leave with a certificate of participation.
2. After completing the HIV, Syphilis, and Hepatitis C Prevention Counseling and Rapid Testing training and receiving a certificate of completion, there are two additional steps. First, a written test covering HIV, syphilis, and HCV prevention counseling, rapid testing skills, and protocol/paperwork must be passed. The dates, locations, and method of signing up for a class are outlined on www.louisianahealthhub.org. Secondly, all persons must practice the finger stick procedure (collecting the blood but NOT running an HIV or SHC test) two times in addition to observing at least two CTR sessions with an existing certified CTR counselor. Thirdly, all persons conducting CTR must successfully complete an observation session with the Regional Prevention Coordinator or other SHHP Prevention staff as arranged by the Prevention Coordinator. Each person has two opportunities to pass the written test and the counselor observation. If the person fails either the test or the observation twice, they must go through the entire process again, beginning with training. Also, the written test must be passed before the observation can be scheduled. If, during the observation session, more than two lancets are required to perform the test, which will result in an automatic failure of that observation.
3. Once the SHHP Training Coordinator assigns a unique counselor number to the counselor, they are fully certified and may conduct CTR.

Steps for Registering a Rapid Testing Site:

1. Regional HIV Coordinator must conduct a site visit and make their recommendation on the site assessment and registration form. This form will then be given to the CTR Supervisor.
2. If the site is favorably observed, CTR Supervisor will assign a site number and mail a certificate with this number on it. A copy of this certificate must be kept on the site premises at all times.

Please Note: Meeting all counselor requirements does not automatically qualify your agency for site approval. Meeting all site requirements does not automatically qualify your agency for funding or free testing materials.

Attachment RT-3.8 (maintain on site-for information only)

Louisiana HIV Prevention Counseling and Rapid Testing Service Delivery Model

Step 1a - Introduce and Orient the Client to the Session

- Introduce yourself to the client.
- Assess client's readiness to receive the results on the same day.
- Offer options for testing (conventional or rapid) including HIV, syphilis and hepatitis c.
- Describe the testing process, what type of specimen will be collected, how long the whole process will take, and what each of the three possible results mean.
- Explain to client that if a preliminary reactive/positive result is received, a confirmatory test should be conducted. The only exception is if Determine shows an antigen only reactive.
- Address Partner Services, including informing the client that if results come back reactive/positive for HIV and/or syphilis, a DIS will contact them to offer additional services.
- Offer anonymous and confidential options, and explain what each mean.
- Obtain Informed Consent.
- Provide appropriate subject information pamphlet for the rapid test being conducted.

Step 1b – Administer the Rapid Test

- Follow applicable universal precautions
- Clearly label the test device being used
- Demonstrate/facilitate specimen collection
- Start Timer

Step 2 – Identify Risk Behaviors and Circumstances

- Engage client in a discussion of risk behavior
- Assess client's previous experience with HIV testing and knowledge about HIV & STDs
- Complete all but results section of HIV Test Form-Part 1

Step 3a – Identify Safer Goal Behaviors

- Give client information on relevant risk and harm reduction strategies
- Use relevant information pamphlets, brochures and/or brief videos
- Have client explain what he/she/they can do to reduce risk
- Assessing client readiness to receive results can continue up until the timer goes off
- Allow time for client to process and respond

Step 3b – Interpret and Deliver the Test Result (after appropriate time as elapsed)

- Follow applicable universal precautions for handling rapid testing materials
- Interpret Test Result (use a second reviewer if needed and client is not present)
- Return to client and give the results immediately in a simple and direct fashion
- Allow time for client to process and respond

Step 4 – Develop Risk Reduction/Action Plan (can be initiated prior to delivery of test results but should be modified, as needed, after results are provided)

- Based on the results of the test and the client's risk profile, assist the client in developing an action plan to further protect their health and the health of their partners.
- Document risk reduction plan in client's file

Step 5 – Offer Referrals and Provide Support (can be initiated prior to delivery of test results but should be modified, as needed, after results are provided)

- Make appropriate referrals and negotiate plans to follow up with the client

Step 6 – Summarize and Close the Session

Attachment RT-3.9 (maintain on site-for information only)

Louisiana Office of Public Health HIV Prevention Counseling and Rapid Testing Skills Observation Form

All HIV prevention counselors and all prospective counselors conducting rapid HIV testing must submit a favorable observation prior to performing rapid testing on patients/clients. Counselors must be re-observed at least once per year thereafter and copies of all observation forms must be maintained in the counselor's personnel file.

Name of Counselor:		***Date Trained:***		**Point Scale:** 0 = not done 5 = deficient 10 = proficient	
Date and Time of Observation:		***Location of Observation:***			

FIRST: Conduct verbal test result quiz with prospective counselor and observe if they ask the client if they have ever tested reactive/positive for HIV, syphilis or hepatitis c: PASS or FAIL (circle one)

If the counselor passed, continue with observation, if they failed then stop here.

	Score	Comments
Counseling Skills-Before Rapid Test Is Run		
1. **Counselor carefully explained rapid testing and potential results.**		
2. **Counselor carefully explained confidential and anonymous testing**		
3. **Counselor obtained written informed consent.**		
4. **Counselor addressed partner services and DIS**		
5. **Counselor gave client subject information pamphlet.**		
6. **Counselor assessed whether client was ready to receive results that day.**		
Counseling Skills-While Rapid Test is Running		
7. **Counselor identified client's risk(s) behaviors & reviewed transmission routes.**		
8. **Counselor identified client's safer goal behaviors(s).**		
9. **Counselor mainly used non-judgmental language and tone in speaking with client.**		
10. **Counselor asked the client open-ended questions.**		
11. **Counselor maintained strong eye contact and positive body language.**		
12. **Counselor offered options and did not give directives.**		
Counseling Skills-After Rapid Test has Run		
13. **Counselor accurately communicated result to client**		
14. **Counselor allowed time for client to understand result.**		
15. **Counselor made appropriate referrals (one to medical care if prelim. pos).**		
16. **Counselor documented and reviewed a risk reduction plan.**		
17. **Counselor identified date of last exposure and reviewed the window period, including possible retesting if client was negative.**		
18. **Counselor discussed client needs if result is preliminary reactive/positive.**		
19. **Counselor accurately completed HIV Test Form-Part 1 (and LINCT form if preliminary reactive/positive).**		

Rapid Test Lab Operation Skills		
20. **Counselor set up lab space and labeled devices properly.**		
21. **Counselor adhered to all Universal Precautions.**		
22. **Counselor carefully instructed/demonstrated how to collect specimen and run the test properly. Counselor did not use more than 2 lancets per test device.**		
23. **Counselor did not contaminate specimen or device.**		
24. **Counselor did not move test during processing.**		
25. **Counselor timed the processing accurately.**		
26. **Counselor accurately interpreted and documented test result**		
27. **Counselor recapped all used vials and disposed of used testing supplies in a biohazard container.**		

Scoring Required to Pass:

-Each section requires 85% correct to pass, and for those items in bold and underlined a score of 10 (adequate) is required. The break down for each section is as follows:

Counseling Skills-Before the Rapid Test is Run = 70 points possible, 60 needed to pass
Counseling Skills-While Rapid Test is Running = 60 points possible, 50 needed to pass
Counseling Skills-After Rapid Test has Run = 70 points possible, 60 needed to pass
Rapid Test Lab Operation Skills = 80 points possible, 65 needed to pass

Regardless of the scoring above, more than two attempts at fingerstick will result in failure to pass the observation.

Name of Person Conducting Observation: _____ _____
Name of person conducting this observation Counselor #

Affiliation of Observer to Counselor (i.e. supervisor, regional coordinator) _____

Signature and Date of Observer Named Above: _____ _____
Signature Date

Write in below the complete physical mailing address where Counselor Certificate should be mailed:

Name of Organization: _____

Street Address: _____City, State, ZIP: _____

Attachment RT-3.10 (maintain on site-for information only)

Louisiana HIV Prevention Counseling, Rapid Testing and Referral Services
Quality Assurance Site Visit Assessment

This form should be completed on the first day of the quality assurance site visit.

SECTION I. Agency Information Assessment Period_____

1. Agency Name_____
2. Name and Title of Supervisor/QA Coordinator_____
3. CLIA Waiver Number_____Expiration Date_____
4. Is CLIA Waiver displayed properly? Yes No
5. Type of Rapid Tests In Use:_____
6. Describe the location where rapid test kits are stored:

_____

_____

7. Are Test Device Temperature Logs Maintained on site? Yes No
8. How is the temperature of stored testing devices monitored:

_____

_____

_____

9. Review the Test Device Temperature Logs for missing entries, days when temperature was out of range, and any corrective actions taken. Record in the table below.

Date	Describe Problem/Issue	Describe Action Taken (if any)

10. Describe where Rapid Testing Controls are stored:

_____

_____

11. Are Rapid Testing Control Logs Maintained on site? Yes No

12. How is the temperature of control kits monitored?

_____

_____

_____

13. Review the Control Kit Temperature Logs for missing entries, days when temperature was out of range, and any corrective actions taken. Record in the table below.

Date	Describe Problem/Issue	Describe Action Taken (if any)

14. Are Daily Test Logs maintained on site? Yes No

15. How well does the site document risk reduction plans in client charts? (review at least 10 charts and indicate what percentage had documented risk reduction plans). _____

_____

16. Are client files maintained appropriately? Yes No

SECTION II. – Comments/Notes/Concerns about rapid testing site.

Use this remainder of this page and the back if needed to make notes about the site's overall rapid testing policies, any additional concerns, and adherences to SHHP protocol.

HIV/STI Results and Linkage into Care or Treatment

Complete this form when the client receives confirmatory (negative or positive) testing on a rapid positive or any positive lab based STI/HIV test results

Client First Name:_____ Client Last Name:_____ Client DOB:_____

Date: ____/____/_____ (MM DD YYYY)

Worker/Counselor ID: _____

Place a label from the STD/HIV Test Form-Part 1 below OR clearly write in the P-number.

(Previously STD43 Form)			FOR POSTIVE TEST RESULTS		
COMPLETE FOR EVERY TEST ADMINISTERED *Leave blank if not tested, circle blood or rapid where applicable*	Circle Result Positive=P Negative=N Indeterminate=I	**If Referred:** Write in referral site. Once follow-up is completed, fill out treatment columns.	**Treatment Date** *MM/DD/YYYY*	**Treatment** Circle the standard treatment given or write in medication and provide dosage.	
Chlamydia: Urine	P N I		/ /	Doxycycline 100mg orally 2x/day for 7 days	Azithromycin 1g orally in a single dose	Levofloxacin 500 mg orally 1x/day for 7 days	Amoxicillin 500 mg orally 3x/day for 7 days
Pharyngeal	P N I						
Anal	P N I			Medication _____ Dose_____ Duration_____			
Gonorrhea: Urine	P N I		/ /	Ceftriaxone 500mg IM 1 dose for persons weighing <150 kg (300 lb)..	Persons weighing ≥150 kg (300 lb),1 g of IM ceftriaxone	Gentamicin 240mg IM in 1 dose PLUS Azithromycin 2g orally in 1 dose	Cefixime 800 mg orally in 1 dose.
Pharyngeal	P N I						
Anal	P N I			Medication _____ Dose_____ Duration_____			
Syphilis: Lab	P N I	☐ Serofast, no treatment needed	/ /	2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose	2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses.	Doxycycline 100 mg orally twice a day for 14 days	Doxycycline 100 mg orally twice a day for 28 days
				Medication _____ Dose_____ Duration_____			
Hepatitis C: Lab	P N I	☐ RNA not detected	/ /	Treatment: _____			
Hepatitis B: Lab	P N I		/ /	Treatment: _____			
HIV: Rapid / Lab	P N I		COMPLETE BELOW				

FOR CLIENTS WITH HIV POSITIVE TEST RESULTS

(Previously HIV Part 2 Form)

ESSENTIAL SUPPORT SERVICES	Need Determined Yes	Need Determined No	If Yes Provided or Referred Yes	If Yes Provided or Referred No
Navigation services for linkage to HIV medical care				
Linkage to HIV medical care				
Medication Adherence support				

PREGNANCY		Yes	No	Don't Know	Decl-ined	Not Asked
Is client pregnant?						
If Yes	Is client in prenatal care?					
If Yes	Does client need perinatal HIV service coordination?					
If Yes	Was client referred to perinatal HIV service coordination?					

HIV CARE INFORMATION	Yes	No	Don't Know	Declined	*FORMAT* MM/DD/YYYY
Has the client ever had a previous positive HIV Test?					Date of first positive HIV Test: / /
Has the client ever had a negative HIV Test?					Date of last negative HIV Test: / /
Has the client ever used or is client currently using antiretroviral medication (ARV)?					Date ARV began:_____/_____/_____
Number of negative HIV tests within 24 months before the current (or first positive) HIV test: _____					Date of most recent ARV use:_____/_____/_____

What was the client's most severe housing status in the past 12 months?	☐ Homeless ☐ Unstably Housed and at Risk of Losing Housing ☐ Stably Housed ☐ Not Asked ☐ Declined to Answer ☐ Don't know
Was client provided with individualized risk reduction counseling?	☐ Yes ☐ No

Attach to Part 1 form and mail to the STD/HIV/Hepatitis Program using double envelope system

Attachment RT-3.12 (maintain on site)

Harm Reduction Worksheet

P Number

Goals	Action Steps	Time Frame
1)		
2)		
3)		

Example of Tools

- Get Tested Regularly ☐
- Talking to partner(s) about testing ☐
- Syringe Service Program ☐
- Accessing PrEP/PEP ☐
- Limit Partners ☐
- Access Primary Care/insurance ☐
- Harm reduction ☐
- Get STI Testing ☐
- Condoms ☐
- Abstinence ☐
- Medication Adherence App ☐
- Other ☐

Note to counselor: This form helps to cover step 4 of the counseling and testing process. It is intended to help guide a conversation with the client to ensure that they are able to identify some goals and practices that work specifically well for them regarding STI/HIV/Hepatitis prevention or accessing care. Use open-ended questions such as, “What are some goals that would work for you for sexual and/or drug use health?” or “What tools will work best for you?” or “What are your strengths/what are you already doing for your sexual health and wellbeing that you want to continue?” This should be a client-centered conversation and non-prescriptive with unique responses for each person.

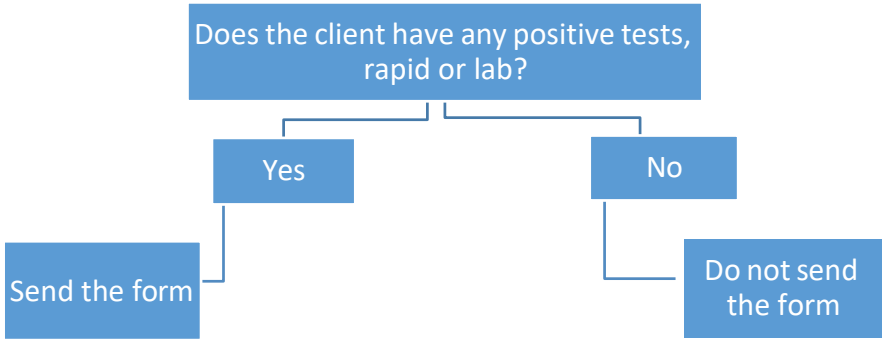
(updated 4/25/24)

LINCT Form Instructions and FAQ

HIV/STI Results and Linkage into Care or Treatment (LINCT)

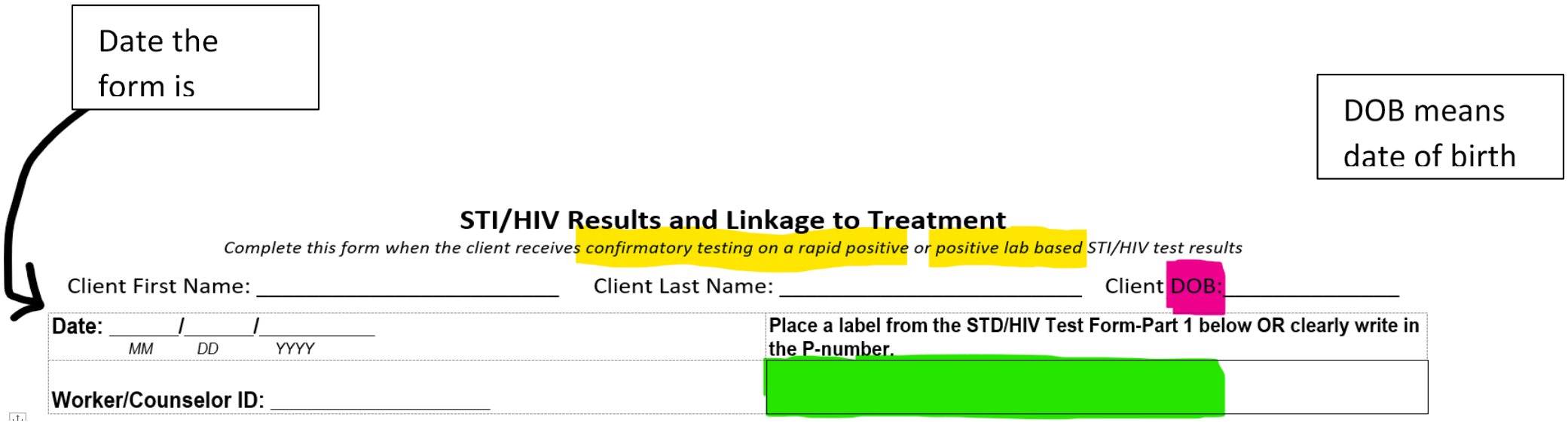
The HIV/STI Results and Linkage into Care or Treatment form, also referred to as the LINCT form, documents confirmatory testing for preliminary STD/HIV positive results and records treatment and linkage to care. The LINCT form should be completed whenever ANY lab-based screening or rapid testing is positive. The form is completed for **confirmatory screening/follow up testing AFTER a rapid or lab-based positive result**. **Do not** fill out the form with rapid test results that are already recorded on the Part 1 form. Negative lab based screening results will be obtained from surveillance information. Inconsistencies/missed results will be addressed by your regional coordinator. Linkage into care or treatment are only counted for clients successfully referred or treated.

- If the client receives a POSITIVE lab test screening result, send this form with the result circled and information on referral and/or treatment if applicable.
- If the client receives a POSITIVE rapid test result, and the confirmatory/lab screening test is NEGATIVE, send this form with the confirmatory test result circled information on referral and/or treatment if applicable.
- If the client receives a POSITIVE rapid test result, and the confirmatory/lab screening test is POSITIVE, send this form with the confirmatory test result circled information on referral and/or treatment if applicable.
- If the client receives a NEGATIVE rapid test result, and the confirmatory/lab screening test is NEGATIVE, do not send this form.



Section by Section Instructions

Section 1: Client and counselor information



The PRIMARY way we can link this form to the correct client is by the P-number. **Please use the sticker or write very clearly.**

Section 2: STD/HIV Results and Linkage to Treatment (Previously the STD43 form)

Fill out the appropriate test section for each positive test result the client received. If the client refuses referral or treatment, please only write Refused in the Referral box. *Counselors/staff/providers should stress the importance of being linked to treatment to all clients.

If the client was given a LAB-BASED screening test, provide a result.
For Rapid+/Rapid+ HIV testing, circle Rapid. All other rapid + is recorded on the part 1 form. Do not record them here.

Referral information includes the name of the clinic or doctor. Follow up with the clinic or client to ensure treatment was completed.

Listed are the standard treatments, circle as applicable. If the treatment was different than those included here, write the details.

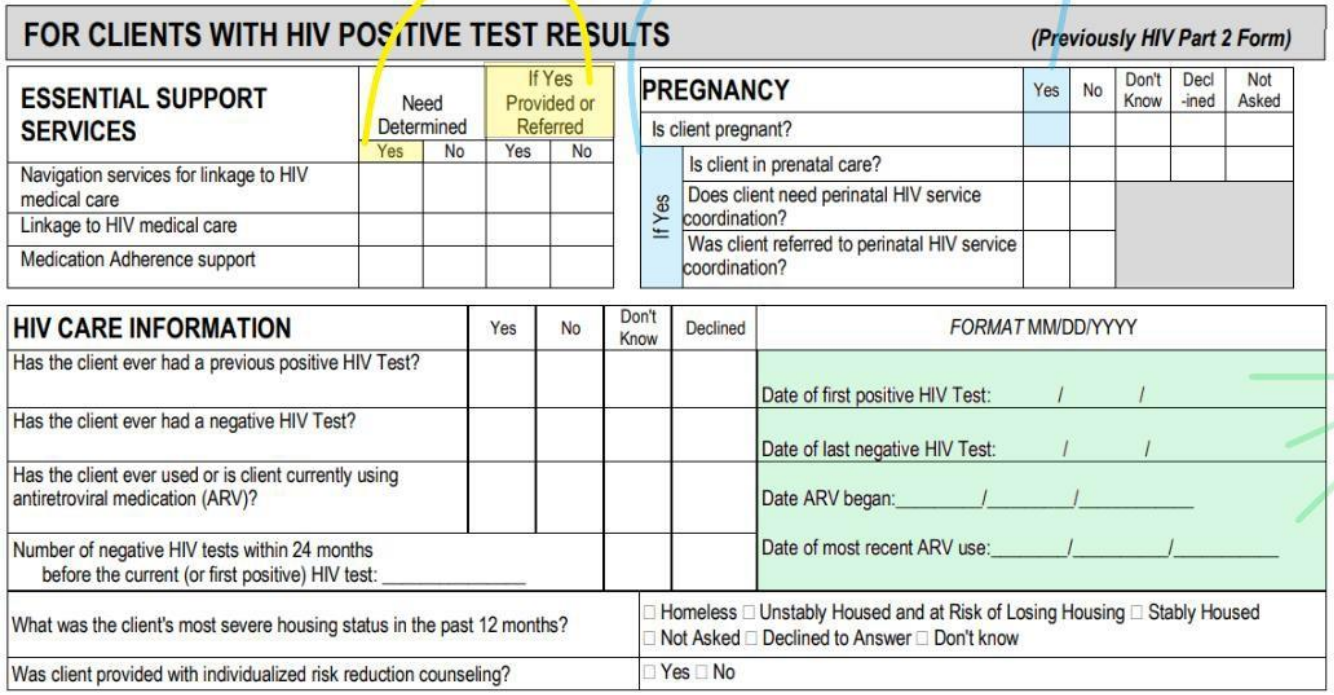
				FOR POSTIVE TEST RESULTS (Previously STD43 Form)		
COMPLETE FOR EVERY TEST ADMINISTERED *Leave blank if not tested, circle blood or rapid where applicable*		**Circle Result** Positive=P Negative=N Indeterminate=I	**If Referred:** Write in referral site. Once follow-up is completed, fill out treatment columns.	**Treatment Date** *MM/DD/YYYY*	**Treatment** Circle the standard treatment given or write in medication and provide dosage.	
Chlamydia:	Urine	P N I		/ /	Doxycycline 100mg orally 2x/day for 7 days	Azithromycin 1g orally in a single dose
	Pharyngeal	P N I			Levofloxacin 500 mg orally 1x/day for 7 days	Amoxicillin 500 mg orally 3x/day for 7 days
	Anal	P N I			Medication _____ Dose_____ Duration_____	
Gonorrhea:	Urine	P N I		/ /	Ceftriaxone 500mg IM 1 dose for persons weighing <150 kg (300 lb)..	Persons weighing ≥150 kg (300 lb),1 g of IM ceftriaxone
	Pharyngeal	P N I			Gentamicin 240mg IM in 1 dose PLUS Azithromycin 2g orally in 1 dose	Cefixime 800 mg orally in 1 dose.
	Anal	P N I			Medication _____ Dose_____ Duration_____	
Syphilis:	Lab	P N I	☐ Serofast, no treatment needed	/ /	2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose	2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses.
					Doxycycline 100 mg orally twice a day for 14 days	Doxycycline 100 mg orally twice a day for 28 days
					Medication _____ Dose_____ Duration_____	
Hepatitis C:	Lab	P N I	☐ RNA not detected	/ /	Treatment: _____	
Hepatitis B:	Lab	P N I		/ /	Treatment: _____	
HIV:	Rapid / Lab	P N I		COMPLETE BELOW		

Section 3: HIV Positives (Previously the HIV Part 2 form)

Complete this section for people testing positive for HIV. This includes newly diagnosed people, people who have been positive for years, people who have had a rapid positive, and a second rapid test, or a lab based positive

If a need was determined, mark yes if assistance was provided or the client was referred. If need was not determined, you can leave provided or referred blank.

If the client is pregnant, please answer the pregnancy questions. If not, leave blank



FOR CLIENTS WITH HIV POSITIVE TEST RESULTS *(Previously HIV Part 2 Form)*

ESSENTIAL SUPPORT SERVICES	Need Determined		If Yes Provided or Referred	
	Yes	No	Yes	No
Navigation services for linkage to HIV medical care				
Linkage to HIV medical care				
Medication Adherence support				

PREGNANCY		Yes	No	Don't Know	Decl -ined	Not Asked
Is client pregnant?						
If Yes	Is client in prenatal care?					
	Does client need perinatal HIV service coordination?					
	Was client referred to perinatal HIV service coordination?					

HIV CARE INFORMATION	Yes	No	Don't Know	Declined	*FORMAT* MM/DD/YYYY
Has the client ever had a previous positive HIV Test?					Date of first positive HIV Test: / /
Has the client ever had a negative HIV Test?					Date of last negative HIV Test: / /
Has the client ever used or is client currently using antiretroviral medication (ARV)?					Date ARV began:_____/_____/_____
Number of negative HIV tests within 24 months before the current (or first positive) HIV test: _____					Date of most recent ARV use:_____/_____/_____
What was the client's most severe housing status in the past 12 months?	☐ Homeless ☐ Unstably Housed and at Risk of Losing Housing ☐ Stably Housed ☐ Not Asked ☐ Declined to Answer ☐ Don't know				
Was client provided with individualized risk reduction counseling?	☐ Yes ☐ No				

If the client knows the exact dates, list them, otherwise approximate or leave blank.

Section 4: Mailing instructions

Attach to Part 1 form and mail to the STD/HIV/Hepatitis Program using double envelope system

Please attach to the Part 1 form and mail to SHHP using a double envelope system:

Testing Department

Office of Public Health

1450 Poydras Ave. Ste. 2136

New Orleans, LA 70112

Type of Test	Storage Temp	Operating Temp	Reading Window
Determine Test Kits	36-86	59-86	20-30 mins
Determine Controls	36-46	(asap)	20-30 mins
INSTI Test Kits	59-86	59-86	1-5 mins
INSTI Controls	36-46	59-86	1-5 mins
Syphilis Health Check Test Kits	39-86	68-78	10-15 mins
Syphilis Health Check Controls	35-46	(asap)	10-15 mins
OraQuick HCV Test Kits	36-86	59-99	20-40 mins
OraQuick HCV Controls	36-46	(asap)	20-40 mins
Sure Check Test Kits	46-86	64-86	15-20
Sure Check Controls	46-86	(asap)	15-20