UCSF Alliance Health Project

ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST

SELF FINGER STICK PROCEDURE CHECKLIST

1. Gather and arrange materials.

a. Instructions (this checklist)

b. Absorbent workspace cover

c. Biohazard sharps container and biohazard bag (within easy reach)

d. Biohazard spill kit (available)

e. Glove

f. Good lighting

g. Alcohol wipe

h. Lancet

i. Cotton balls

j. Bandage

k. Loop

2. Put on glove.

3. Perform a finger stick.

a. Cleanse the puncture site with an alcohol wipe and allow to dry.

b. Activate lancet at proper site.

c. Immediately dispose of lancet into sharps container.

4. Collect Specimen.

a. Wipe away the first drop of blood with a cotton ball.

b. Touch loop to second drop of blood.

c. Examine loop to make sure it is filled.

d. Place loop into biohazard bag

5. Press clean cotton ball against the puncture site.

6. Place bandage on puncture site.

7. Dispose of any remaining biohazardous materials, including the chuck, into biohazard bag.

8. Remove gloves and put them into biohazard bag.

UCSF Alliance Health Project

ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST

CHECKLIST FOR COLLECTION FROM SAMPLE VIAL

1. Gather and arrange materials.

a. Instructions (this checklist)

b. Absorbent workspace cover

c. Biohazard bag (within easy reach)

d. Biohazard spill kit (available)

e. Gloves

f. Good lighting

g. Test kit pouch

h. Test kit stand

i. Specimen collection loop

j. Clock and thermometer

k. Pen

l. Client ID stickers

m. Quality Assurance (QA) Log

n. Client Encounter Form

o. Box of external controls

2. Examine test kit pouch. It must be

a. Unopened

b. Be between 59°F and 99°F

c. Contain an absorbent packet (desiccant)

3. (First Entry Only) Record Test Provider ID and date on the QA Log.

4. Record Test Name on the QA Log.

5. Record Lot Number on the QA Log.

6. Record Expiration Date on the QA Log.

7. Record color of external control vial on the QA Log.

8. Open test kit pouch and remove vial of reagent.

9. Affix client ID sticker to vial of reagent.

10. Affix client ID stickers to the Client Encounter Form and QA Log.

11. Open vial of reagent and place in test kit stand.

12. Put on gloves.

13. Open external control vial.

14. Insert loop into external control vial and obtain sample.

15. Ensure loop is full (with no bubbles).

16. Stir loop into vial of reagent, then dispose of loop into the biohazard bag.

17. Close external control vial and return to box.

18. Insert test kit device into vial of reagent.

19. Dispose of any remaining biohazardous material.

20. Remove gloves and put them in the biohazard bag.

21. Record Begin Test Time on the QA Log.

22. Record Begin Test Temperature on the QA Log.

Test must develop for at least 20 minutes and not more than 40 minutes.

23. Record Result on the QA Log.

24. Record End Test Time on the QA Log.

25. Record End Test Temperature on the QA Log.

*** During proficiency test only.**

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HIV/HCV Rapid Testing Quality Assurance (QA) Log

Test Provider ID	**Date**

Practice

Client ID	Test Name	Lot Number	Expiration Date MM-DD-YYYY	Begin Test Time Begin Test Temp.	End Test Time End Test Temp.	HIV Result	HCV Result	Vial Color
	☐ OraQuick HIV ☐ INSTI HIV ☐ OraQuick HCV			☐ AM ☐ PM °F	☐ AM ☐ PM °F	☐ Preliminary Positive ☐ Negative ☐ Invalid	☐ Reactive ☐ Non-Reactive ☐ Invalid	☐ White/Clear ☐ Black ☐ Red

Proficiency

Client ID	Test Name	Lot Number	Expiration Date MM-DD-YYYY	Begin Test Time Begin Test Temp.	End Test Time End Test Temp.	HIV Result	HCV Result	Vial Color
	☐ OraQuick HIV ☐ INSTI HIV ☐ OraQuick HCV			☐ AM ☐ PM °F	☐ AM ☐ PM °F	☐ Preliminary Positive ☐ Negative ☐ Invalid	☐ Reactive ☐ Non-Reactive ☐ Invalid	☐ White/Clear ☐ Black ☐ Red
	☐ OraQuick HIV ☐ INSTI HIV ☐ OraQuick HCV			☐ AM ☐ PM °F	☐ AM ☐ PM °F	☐ Preliminary Positive ☐ Negative ☐ Invalid	☐ Reactive ☐ Non-Reactive ☐ Invalid	☐ White/Clear ☐ Black ☐ Red
	☐ OraQuick HIV ☐ INSTI HIV ☐ OraQuick HCV			☐ AM ☐ PM °F	☐ AM ☐ PM °F	☐ Preliminary Positive ☐ Negative ☐ Invalid	☐ Reactive ☐ Non-Reactive ☐ Invalid	☐ White/Clear ☐ Black ☐ Red

10. PrEP Navigation and Follow-up for Unknown or Negative HIV Status

Applying OA criteria, is the client eligible for PrEP referral?

◯ (1) Yes ◯ (0) No

Was the client referred to a PrEP prescriber?

◯ (1) Yes ◯ (0) No → **Why not?** *(mark one - select primary reason):*

◯ (1) Client not interested in PrEP ◯ (2) Other *(specify)*: _____

Type of referral *(mark one)*:

◯ (1) Internal ◯ (2) External

Referral date *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

Did the client attend first appointment? *(mark one)*

◯ (1) Yes → **Appointment date** *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

◯ (0) No

◯ (8) Don't know

Did the client obtain a PrEP prescription? *(mark one)*

◯ (1) Yes

◯ (0) No

◯ (8) Don't know

Did the client initiate taking PrEP? *(mark one)*

◯ (1) Yes → **PrEP initiation date** *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

◯ (0) No

◯ (8) Don't know

Was client assisted with navigation or linkage to a PrEP prescriber *(excluding benefits navigation)*?

◯ (1) Yes ◯ (0) No

Is this a follow-up session for a client who is currently on PrEP?

◯ (1) Yes → **What follow-up session is this?** *(mark one)*

◯ (0) No

◯ (1) 1-month

◯ (2) 3-month

◯ (3) 9-month

◯ (4) 12-month

◯ (5) Other *(specify)*: _____

11. PrEP Support Services

	Screened for need	Need identified	Provided or referred
PrEP medication adherence support	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No

CLIENT ENCOUNTER FORM

1. Administrative Information

OA unique ID *(enter or adhere)*: ☐☐☐☐☐☐☐☐☐☐

Session date *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

Provider ID: ☐☐☐☐

Data entry ID: ☐☐☐☐

Agency ID: ☐☐☐☐☐

Location ID: ☐☐☐☐☐

Program announcement:

◯ PS18-1802 ◯ Other *(specify)*: _____

2. Client Identification

LEO client ID: ☐☐☐☐☐☐☐☐☐☐☐☐

CalREDIE person ID *(LHJ use only)*: ☐☐☐☐☐☐☐☐☐☐

Legal first name:

Legal middle name:

Legal last name:

Alternate first name: *(alias, preferred,maiden,etc.)*

Alternate middle name: *(alias, preferred,maiden,etc.)*

Alternate last name: *(alias, preferred,maiden,etc.)*

Current street address:

City:

County:

State/territory:

ZIP code: ☐☐☐☐☐

Social security number: ☐☐☐-☐☐-☐☐☐☐

Primary phone number *(xxx-xxx-xxxx)*: ☐☐☐-☐☐☐-☐☐☐☐

Secondary phone number *(xxx-xxx-xxxx)*: ☐☐☐-☐☐☐-☐☐☐☐

E-mail address:

3. Client Demographics *(continued on page 2)*

Date of birth *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

Current gender identity *(mark one)*:

◯ (1) Male

◯ (2) Female

◯ (3) Trans male/transman

◯ (4) Trans female/transwoman

◯ (5) Genderqueer or non-binary

◯ (6) Identity not listed *(specify)*: _____

◯ (9) Declined to answer

Sex assigned at birth *(mark one)*:

◯ (1) Male

◯ (2) Female

◯ (9) Declined to answer

Sexual orientation *(mark one)*:

◯ (1) Heterosexual or straight

◯ (2) Bisexual

◯ (3) Gay, lesbian, or same gender loving

◯ (4) Orientation not listed *(specify)*: _____

◯ (8) Questioning/unsure/client doesn't know

◯ (9) Declined to answer

3. Client Demographics *(continued from page 1)*

Ethnicity *(mark one)*:

- ◯ (1) Hispanic or Latinx *(specify)*: _____
- ◯ (2) Not Hispanic or Latinx
- ◯ (8) Client doesn't know
- ◯ (9) Declined to answer

Race *(mark all that apply)*:

- ☐ (1) Black/African American
- ☐ (1) American Indian/Alaska Native
- ☐ (1) Asian *(specify)*: _____
- ☐ (1) Native Hawaiian/Pacific Islander *(specify)*: _____
- ☐ (1) White
- ☐ (1) Client doesn't know
- ☐ (1) Declined to answer

4. HIV Testing History

HIV test before today? *(mark one)*

- ◯ (1) Yes → **Most recent HIV result received** *(mark one if tested before today)*:
  - ◯ (1) Negative
  - ◯ (2) Positive*
  - ◯ (3) Preliminary positive* *(no confirmatory result received)*
  - ◯ (4) Inconclusive, invalid
  - ◯ (8) Client doesn't know
  - ◯ (9) Declined to answer
- ◯ (0) No
- ◯ (8) Client doesn't know
- ◯ (9) Declined to answer

5. Client Pre-Exposure Prophylaxis (PrEP) Awareness and Use

Ever heard of PrEP?	Currently taking daily PrEP medication?	Used PrEP anytime in the last 12 Months?	If not on PrEP, wants PrEP?
◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No

6. Priority Populations

In the <u>past 5 years</u>, has the client had a male sex partner?

- ◯ (1) Yes
- ◯ (0) No

In the <u>past 5 years</u>, has the client had a female sex partner?

- ◯ (1) Yes
- ◯ (0) No

In the <u>past 5 years</u>, has the client had a trans or genderqueer/non-binary sex partner?

- ◯ (1) Yes
- ◯ (0) No

In the <u>past 5 years</u>, has the client injected drugs that were not prescribed to them by a medical care provider?

- ◯ (1) Yes
- ◯ (0) No

Has the client <u>ever</u> injected drugs that were not prescribed to them by a medical care provider?

- ◯ (1) Yes
- ◯ (0) No

7. Essential Support Services

	Screened for need	Need identified	Provided or referred
Health benefits navigation and enrollment	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No
Behavioral health services	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No
Social services	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No

8. HIV Testing

HIV test conducted? *(mark one)*

- ◯ (1) Yes, confidential
- ◯ (2) Yes, anonymous
- ◯ (0) No, test not done ***(if 'no', <u>SKIP</u> to Section 9)***

Specimen collection date *(mm/dd/yyyy)*: ☐☐/☐☐/☐☐☐☐

Final test type *(mark one):*

- ◯ (1) Rapid test → **Rapid test specimen type** *(mark one):*
  - ◯ (1) Venipuncture
  - ◯ (2) Finger stick
  - ◯ (3) Oral

  Rapid test result *(mark one):*
  - ◯ (1) Preliminary positive*
  - ◯ (2) Negative
  - ◯ (3) Invalid
- ◯ (2) Laboratory-based test → **Laboratory-based test result** *(mark one):*
  - ◯ (1) Positive*
  - ◯ (2) Negative
  - ◯ (3) Inconclusive, further testing needed

***NOTE:** **If current or most recent HIV test result is preliminary positive or positive, complete the *Supplemental Client Encounter Form - HIV Care and Services*, in addition to this form.**

Was the final HIV test result provided to client? *(mark one)*

- ◯ (1) Yes, from **<u>this</u>** agency
- ◯ (2) Yes, from **<u>another</u>** agency
- ◯ (0) No

9. Other Testing at Encounter

Was the client tested for other infections?

- ◯ (1) Yes
- ◯ (0) No

Tested for syphilis?	Tested for gonorrhea?	Tested for chlamydia?	Tested for hepatitis C virus?
◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No	◯ (1) Yes ◯ (0) No