

Supplemental HIV Test Result

HIV STATUS UPDATE:

INSTRUCTIONS: *This form must be submitted to the PrEP Program if the patient has not received their medication within the last 30 days or the Division of Pharmacy Services will not release any more medication.*

1. The provider must:

- Review the HIV test result, and record it by checking the appropriate box in Section 2 along with the date of the test.
- If the medication is being sent to a local health department or a clinical site, fill in the appropriate address,
- Sign and date to certify the HIV test result.
- Fax the completed form to the Division of Disease Prevention PrEP program at: **804-864-8053**. Do not fax this form to the Division of Pharmacy Services.

Record and Certify HIV Test Result:

Patient's name: _____ Date of Birth: ____/____/____
MM DD YYYY

Is this patient HIV negative? Yes No Date of last negative HIV test: ____/____/____
MM DD YYYY

*Name of health department or clinic for medication pick-up: _____

Address: _____

City: _____ State: VA ZIP: _____

** Complete only if the client is picking up medication at a clinical site or local health department. For clients picking up at a local health department be sure there is a completed encounter for each medication pick-up.*

By signing below, you:

- Confirm that you have evidence of the patient's HIV status and risk.
- Certify the information on this form is accurate and complete to the best of your knowledge.

Health Care Provider Signature (Do Not Leave Blank)

Today's Date (Do Not Leave Blank)

Health Care Provider – Print First & Last Name

For DDP Use Only - Approved By:

340b

Signature

Date

Fax completed form to 804-864-8053. Do not fax this form to the Division of Pharmacy Services.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-864-VDH (TDD/TTY call 711).