This form is for all applicants 5 years old and above

Skip the Pregnancy Declaration for male applicants;
and female applicants of non-reproductive age group

International Organization for Migration (IOM)
The UN Migration Agency

URINE TEST AND PREGNANCY DECLARATION FORM

Programme: ☐ Canada ☐ Australia ☐ United Kingdom

Last Name: _____ Sex: ☐ Male ☐ Female

First Name: _____ Age: _____

Appointment Date: _____

Kindly fill out this part on your appointment date.

TO BE SIGNED AFTER HIV COUNSELLING

Last Menstruation Period (LMP) (First day of last menstrual cycle): _____

☐ **Not Pregnant**	☐ **Pregnant**
	This is to certify that I am or may be pregnant and I am giving my permission to perform the x-ray. I am fully aware of all the possibilities of this procedure, and I have received counselling.
_____ Signature	_____ Signature

To be completed by IOM Medical Staff

PT Result: ☐ Negative ☐ Positive

UA Dipstick: _____ Protein

_____ Glucose

_____ Blood

Specimen Collector Signature:

HIV TESTING

HTS

The Department of Health (DOH) has an existing program for the prevention and control of the Human Immunodeficiency Virus (HIV) in the Philippines. The Epidemiology Bureau (EB) of DOH is mandated by Republic Act 11166 & 11332 to collect information that will be used in planning activities to help stop the spread of HIV and to support and treat those diagnosed with HIV. Your full cooperation is very important to this program. Please answer all questions as honestly as possible.

ABOUT THE TEST

What is HIV testing?
An HIV test refers to a procedure used to identify if you have antibodies to HIV -- the virus that causes AIDS. A specimen, usually blood, and a DOH-Food and Drug Administration (FDA)-registered diagnostic kit is needed to perform the test. The test may be performed by a trained/supervised healthcare worker or lay person, or by oneself, depending on the modality.

If the first test (screening) is reactive, another test (confirmatory) will be done to make sure that the first test is confirmed to be positive. A positive test means you have been infected with HIV. A non-reactive or negative test means you are not infected or your body has not produced the sufficient level of antibodies (within window period) that can be detected by the HIV rapid diagnostic test kits. If you are non-reactive or negative, and had a recent exposure within the window period, you need to undergo another test 4 weeks after your risk exposure.

Confidentiality of HIV Testing
Your personal information and HIV test result is confidential adherent to the provisions of RA 11166 Philippine HIV and AIDS Policy Act, RA 10173 Data Privacy Act of 2012 and its IRR of 2016.

INFORMED CONSENT

I, CLIENT / CHILD / PROXY CONSENT PROVIDER, was given information about HIV, its testing process, and was able to ask questions about HIV. I agree to undergo HIV testing.

TO BE SIGNED AFTER HIV COUNSELLING

Name and Signature

☐ **Verbal Consent** *(applicable for clients 15 y/o and above undergoing either CBS or self-testing)*

By providing my contact details, I am allowing the HTS provider to contact me on updates regarding the services provided including but not limited to: test result, combination prevention services, and notification for retesting.

Contact Number: _____

Email address: _____

PERSONAL INFORMATION SHEET (HTS FORM)

All information given will be STRICTLY CONFIDENTIAL. Please fill out this form COMPLETELY and as honestly as possible. Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

DEMOGRAPHIC DATA

1. **Test Date:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

2. **PhilHealth Number:** ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ ☐ Not enrolled in PhilHealth

3. **PhilSys Number:** _____ ☐ No PhilSys Number

4. **Name (Full name)**
   First Name _____ Middle Name _____ Last Name _____ Suffix (Jr, Sr, III, etc) _____

5. **First 2 letters of mother's FIRST name** ☐☐ **First 2 letters of father's FIRST name** ☐☐ **Birth order (i.e. among mother's children)** ☐☐

6. **Birth date:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year **Age:** ☐☐ Age in months (for less than 1 year old): ☐☐

7. **Sex** *(assigned at birth):* ☐ Male ☐ Female **Gender identity:** ☐ Man ☐ Woman ☐ Others: _____

8. **Current Place of Residence:** City/Municipality: _____ Province: _____
   Permanent Residence: City/Municipality: _____ Province: _____
   Place of Birth: City/Municipality: _____ Province: _____

9. **Nationality:** ☐ Filipino ☐ Other, please specify: _____

10. **Civil Status:** ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

11. **Are you currently living with a partner?** ☐ No ☐ Yes **Number of children:** ☐☐

12. **Are you currently pregnant?** *(for female clients only)* ☐ No ☐ Yes

EDUCATION & OCCUPATION

13. **Highest Education Attainment?** ☐ No grade completed ☐ Pre-school ☐ Highschool ☐ Vocational ☐ Elementary ☐ College ☐ Post-Graduate

14. **Are you currently in school?** ☐ No ☐ Yes

15. **Are you currently working?**
    ☐ Yes. Current occupation (main source of income): _____
    ☐ No. Previous occupation in the past 12 months: _____

16. **Did you reside or work overseas/abroad in the past 5 years?** ☐ No ☐ Yes
    Did you work overseas/abroad? ☐ No ☐ Yes, specify year of return from last contract: ☐☐☐☐
    Where were you based? ☐ On a ship ☐ Land
    What country did you last work in? *(For seafarer, last port of exit)* _____

HIV TESTING

HTS

You may answer this on your own or with assistance from a counselor or healthcare provider

HISTORY OF EXPOSURE / RISK ASSESSMENT

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***Answer all*. Please check the appropriate column for each item, and provide history of risk if applicable.**

Did your birth mother have HIV when you were born? ☐ Do not know ☐ No ☐ Yes

	History of sexual activity (oral/anal/vaginal)		Date of most recent ***anal or neo/vaginal*** sex (MM/YYYY)	Date of most recent **CONDOMLESS** *anal or neo/vaginal* sex (MM/YYYY)
	No	Yes		
Sex with a **MALE***	☐	☐	_____	_____
Sex with a **FEMALE****	☐	☐	_____	_____

**Sex partners whose assigned sex at birth is MALE, including transgender and/or nonbinary*

***Sex partners whose assigned sex at birth is FEMALE, including transgender and/or nonbinary*

	No	**Yes**	**Date of most recent risk (MM/YYYY)**
Paid for sex (in cash or kind)	☐	☐	_____
Received payment (cash or in kind) in exchange for sex	☐	☐	_____
Had sex under the influence of drugs	☐	☐	_____
Shared needles in injection of drugs	☐	☐	_____
Received blood transfusion	☐	☐	_____
Occupational exposure (needlestick/sharps)	☐	☐	_____

REASONS FOR HIV TESTING

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Please check all that apply.

☐ Possible exposure to HIV ☐ Employment - Overseas/Abroad ☐ Requirement for insurance

☐ Recommended by physician/nurse/midwife ☐ Employment - Local/Philippines ☐ Other (please specify): _____

☐ Referred by a peer educator ☐ Received a text message/email encouraging me to get an HIV test

PREVIOUS HIV TEST

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Have you ever been tested for HIV before? ☐ No ☐ Yes. Date of most recent test? ☐☐ Month ☐☐☐☐ Year

Which HTS provider (facility or organization) conducted the test? _____ City/Municipality: _____

What was the result? ☐ Reactive ☐ Non-reactive ☐ Indeterminate ☐ Was not able to get result

To be filled out by HTS PROVIDER only

MEDICAL HISTORY & CLINICAL PICTURE

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Please check all that apply.

☐ Current TB patient ☐ Diagnosed with other STIs ☐ Taken PEP

☐ With hepatitis B ☐ With hepatitis C ☐ Taking PrEP

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Clinical Picture: ☐ Asymptomatic ☐ Symptomatic Describe S/Sx: _____

World Health Organization (WHO) Staging: _____ ☐ No physician to do staging

TESTING DETAILS

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Client type: *(select one)* ☐ Inpatient ☐ Walk-in/outpatient ☐ Persons Deprived of Liberty (PDL) ☐ Mobile HTS / Outreach in physical venues. *Specify venue:* _____

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Mode of reach: *(select all that apply)* ☐ Clinical reach ☐ Online ☐ Index testing ☐ Social and sexual network testing ☐ Outreach in physical venues

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☐ **Refused HIV Testing** *Reason for refusal:* _____

☐ **Accepted HIV Testing**

HIV testing modality: ☐ Facility-based testing (FBT) ☐ Non-laboratory FBT ☐ Community-based ☐ Self-testing

Linkage: *(choose all that apply)* ☐ Refer to ART ☐ Advise for re-testing in _____ Months _____ Weeks

☐ Refer for Confirmatory *Suggested date: (MM/DD/YYYY)* _____

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Other services provided to client:

☐ HIV 101 ☐ Condoms, # distributed: _____

☐ IEC materials ☐ Lubricants, # distributed: _____

☐ Risk reduction planning ☐ Offered social and sexual network testing (SSNT)

☐ Referred to PrEP or had given PEP ☐ Accepted SSNT

☐ Other services: _____

Inventory Information

Brand of test kit used:

Number of test kit used:

Test kit lot number:

Expiration date (mm/dd/yyyy):

HTS PROVIDER DETAILS

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Name of Testing Facility/Organization: _____

Complete Mailing Address: _____

Contact Numbers: _____ **Email address:** _____

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Primary HTS provider: *(select one)* ☐ HIV Counsellor ☐ Medical Technologist ☐ CBS Motivator ☐ Others: _____

Name & Signature of service provider: _____

END