Introduction

The reporting of newly and previously diagnosed positive cases to the CT DPH is essential in the planning and implementation of HIV prevention and care interventions. This guidance provides CT DPH funded programs with the process on how to accurately report HIV cases in a timely manner. It also includes copies of the required forms necessary for reporting to DPH, and information regarding where and to whom the forms must be sent. We hope that this document will assist you with the necessary information needed to report all newly or previously diagnosed HIV positive cases to the CT DPH HIV Prevention Program.

Respectfully yours,

Marianne Buchelli, MPH, MBA
CT DPH Health Program Supervisor
Procedure for Reporting Newly or Previously Confirmed HIV Positive Cases to DPH:

a. Complete EvaluationWeb 2015 HIV Test Template Forms Parts 1, 2 and 3 for all confirmed HIV positive results (See Appendix A).

b. Submit all completed confirmed HIV positive EvaluationWeb 2015 HIV Test Template Forms Parts 1, 2 and 3 to the CT DPH HIV Prevention Program.

   i. Outreach, Testing and Linkage (OTL) programs should mail all confirmed HIV positive Test Forms to DPH, attention to Susan Major. A confirmatory email will be sent to programs submitting HIV Test Forms to ensure the receipt of the forms.

   ii. Expanded Testing Initiative (ETI) programs (i.e., directly and non-directly funded) should mail all confirmed positive HIV Test Forms to DPH, attention to Dulce Dones-Mendez. A confirmatory email will be sent to programs submitting HIV Test Forms to ensure the receipt of the forms.

   iii. All programs should contact Partner Services to report HIV Positive case.

c. Report to the CT DPH HIV Surveillance Program all confirmed HIV positive results via:

   1) Phone:

      CT DPH HIV Surveillance Program

      860-509-7900

      OR

   2) Mail:

      Using the ‘Adult HIV/AIDS Confidential Case Report Form’

      Instructions on how to complete the Adult HIV/AIDS Confidential Case Report Form

      (See Appendix B) and mail it to:
      Connecticut Department of Public Health
      410 Capitol Ave MS# 11ASV
      P.O Box 340308
      Hartford, CT 06134
d. For HIV Testing sites **not using** the CT DPH State Laboratory:

If an Outreach, Testing, and Linkage (OTL) or Expanded Testing Initiative (ETI) (directly or non-directly funded) site **is not using** the CT DPH State Laboratory for HIV Testing confirmatory results, providers must submit proof of confirmatory result along with the Adult HIV/AIDS Confidential Case Report Form to the CT DPH HIV Surveillance Program.

e. For HIV Testing sites **using** the CT DPH State Laboratory:

If an Outreach, Testing, and Linkage (OTL) or Expanded Testing Initiative (ETI) (directly or non-directly funded) site **is using** the CT DPH State Laboratory for HIV Testing Confirmatory results, providers must submit one tube of whole blood, serum or plasma. Use of Orasure has been discontinued by the CT DPH Lab.

(See Appendix C)

**Note.** Copies of the HIV Test Forms for both positive and negative test events must be kept on file at the site and secured in a locked file cabinet.

**Reporting Do’s and Don’ts**

**Do’s:**

- ✓ Send Parts 1, 2, and 3 of the 2015 HIV Test Forms
- ✓ Ensure that forms are completed appropriately
- ✓ Mail forms as soon as possible
- ✓ Include name and return address on envelopes
- ✓ Use the most current HIV Test Forms
- ✓ Make copies of the HIV Test Forms Parts 1, 2 and 3 for your records
- ✓ Contact DPH HIV Prevention and HIV Surveillance Programs, if you have any questions regarding submitting all required information

**Don’ts:**

- ✗ Mail confidential personal health information (PHI) to the HIV Prevention Program that includes any demographic information such as name, date of birth, address, gender, etc.
- ✗ Wait more than 15 days upon receipt of confirmation to submit HIV Test Forms to DPH
- ✗ Submit any HIV Test Forms without Form ID Labels
APPENDICES
## APPENDIX A

### EVALUATIONWEB® 2015 HIV TEST TEMPLATE

**PART ONE**

<table>
<thead>
<tr>
<th>Section</th>
<th>Date (MM/DD/YYYY)</th>
<th>Sample Date (MM/DD/YYYY)</th>
<th>HIV Test 1</th>
<th>HIV Test 2</th>
<th>HIV Test 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program Announcement (select only one):**

- PS12-1201 Category A
- PS12-1201 Category B
- PS12-1202 Category C
- PS12-1203 CAPUS
- PS11-1113 Category 4-NVSM
- PS10-1003
- Other: [Name] [ID Number]

**Worker ID:**

- Anonymously Confidentially
- Test Not Offered Declined Testing
- Other:

**Test Technology:**

- Conventional Rapid NAAT/RNA Testing
- Other:

**Test Result:**

- Positive/Reactive
- Negative
- Indeterminate
- Invalid
- No Result

**Result Provided:**

- Yes
- No
- Client obtained results from another agency
- Client declined to discuss behavioral risk factors

**Date of Birth (enter 01/01/1900 if unknown):**

**Client State (use USPS abbreviation):**

**Client County:**

**Client ZIP Code:**

**Client Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino
- Other

**Client Race (check all that apply):**

- American IN/AA Native
- African
- Asian
- Black/African American
- Native H/Pac Islander
- Other

**Client Assigned Sex at Birth:**

- Male
- Female
- Other

**Client Current Gender Identity:**

- Male
- Female
- Transgender MTF
- Transgender FTM
- Transgender Unspecified
- Declined
- Not Asked

**Additional (specify):**

**Previous HIV Test:**

- Yes
- No

**If Yes, what is the client’s self-reported result?:**

- Positive
- Negative
- Preliminary
- Positive Indeterminate
- Declined
- Not Asked

**Section Activities (enter codes from page 3):**

- L1
- L2
- L3
- L4

**Local Use Fields:**

- L5
- L6
### EVALUATIONWEB® 2015 HIV TEST TEMPLATE

#### PART TWO

<table>
<thead>
<tr>
<th>Local Use Fields</th>
<th>CDC Use Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>L5</td>
<td>C3</td>
</tr>
<tr>
<td>L6</td>
<td>C4</td>
</tr>
<tr>
<td>L7</td>
<td>C5</td>
</tr>
<tr>
<td>L8</td>
<td>C6</td>
</tr>
<tr>
<td>L9</td>
<td>C7</td>
</tr>
<tr>
<td>L10</td>
<td>C8</td>
</tr>
<tr>
<td>L11</td>
<td>C9</td>
</tr>
<tr>
<td>L12</td>
<td></td>
</tr>
<tr>
<td>L13</td>
<td></td>
</tr>
<tr>
<td>L14</td>
<td></td>
</tr>
<tr>
<td>L15</td>
<td></td>
</tr>
<tr>
<td>L16</td>
<td></td>
</tr>
<tr>
<td>L17</td>
<td></td>
</tr>
</tbody>
</table>

**Enter or adhere form ID:**

**CDC requires the following information on all preliminary and confirmed HIV-positive clients:**

#### Was the client referred to HIV medical care?

<table>
<thead>
<tr>
<th>Option</th>
<th>Reason the client not referred to HIV Medical Care?</th>
<th>Did the client attend the first appointment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>□ Client Already in Care</td>
<td>□ Confirmed: Access Not Service</td>
</tr>
<tr>
<td>Yes</td>
<td>□ Confirmed: Did Not Access Service</td>
<td>□ First medical appointment within 90 days of the HIV test?</td>
</tr>
<tr>
<td>Don't know</td>
<td>□ Pending</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td>□ Lost to Follow-Up</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>□ No Follow-Up</td>
<td>□ Don't Know</td>
</tr>
<tr>
<td></td>
<td>□ Don't Know</td>
<td></td>
</tr>
</tbody>
</table>

#### Was the client referred to/contacted by Partner Services?

<table>
<thead>
<tr>
<th>Option</th>
<th>Was the client interviewed for Partner Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>□ No</td>
</tr>
<tr>
<td>Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Don't know</td>
<td>□ Don't know</td>
</tr>
</tbody>
</table>

#### Was the client referred to HIV Prevention Services?

<table>
<thead>
<tr>
<th>Option</th>
<th>Did the client receive HIV Prevention Services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>□ No</td>
</tr>
<tr>
<td>Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Don't know</td>
<td>□ Don't know</td>
</tr>
</tbody>
</table>

#### What was the client’s most severe housing status in the past 12 months (check only one)?

<table>
<thead>
<tr>
<th>Housing Status</th>
<th>Not Asked</th>
<th>Declined to Answer</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literally Homeless</td>
<td>□ Not Asked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstably Housed or At Risk of Losing Housing</td>
<td>□ Declined to Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stably Housed</td>
<td>□ Don’t Know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### If female, is the client pregnant?

<table>
<thead>
<tr>
<th>Option</th>
<th>Is the client in prenatal care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>□ No</td>
</tr>
<tr>
<td>Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Declined</td>
<td>□ Declined</td>
</tr>
<tr>
<td>Not Asked</td>
<td>□ Not Asked</td>
</tr>
</tbody>
</table>

#### Prior to the client testing positive during this testing event, was she/he previously reported to the jurisdiction’s surveillance department as being HIV-positive?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>□ No</td>
</tr>
<tr>
<td>Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>Don’t know</td>
<td>□ Don’t know</td>
</tr>
</tbody>
</table>

**Notes:**

---

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### EVALUATIONWEB® 2015 HIV TEST TEMPLATE

**PART THREE**

| 22 | Agenerase (amprenavir) |
| 30 | Atripla (tipranavir, TPV) |
| 32 | Atripla (efavirenz/entricitabine/tenofovir DF) |
| 24 | Comblivir (lamivudine/zidovudine, 3TC/AZT) |
| 30 | Complera (entricitabine, rilpivirine/tenofovir DF, FTC/TPV/TDF) |
| 06 | Crizalivir (indinavir, IDV) |
| 37 | Dovonex (rilpivirine, RPV) |
| 11 | Emtriva (entricitabine, FTC) |
| 03 | Epivir (lamivudine, 3TC) |
| 28 | EpiGram (abacavir/lamivudine, ABC/3TC) |
| 25 | Fortovase (saquinavir, SQV) |
| 19 | Fuzone (indinavir, T20) |
| 19 | Hepsera (adefovir) |
| 02 | Hivrid (zalcitabine, 3TC) |
| 23 | Hydronuxera |
| 18 | Invirase (saquinavir, SQV) |
| 34 | Intelence (etravirine) |
| 36 | Isentress (ritonavir, RTV) |
| 16 | Kaletra (lopinavir, ritonavir) |
| 08 | Lexiva (lopinavir, RTV) |
| 07 | Norvir (ritonavir, RTV) |
| 33 | Prezista (darunavir,DRV) |
| 09 | Rescriptor (delavirdine, DLV) |
| 26 | Retrovir (zidovudine, ZDV, AZT) |
| 15 | Reyataz (atazanavir, ATV) |
| 08 | Saldnozir (Fortovase, invirase) |
| 36 | Selzentry (maraviroc) |
| 39 | Stratia (elvitegravir/cobicistat/tenofovir/entricitabine) |
| 21 | Stiva (efavirenz, EV) |
| 40 | Truvada (dolutegavir) |
| 13 | Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) |
| 27 | Truvada (tenofovir DF/entricitabine, TDF/FTC) |
| 01 | Viread (tenofovir DF, 3TC, FTC) |
| 14 | Viread (tenofovir DF, TDF) |
| 04 | Zentri (zidovudine, 3TC) |
| 20 | Ziagen (abacavir, ABC) |
| 80 | Other |
| 99 | Unspecified |

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APPENDIX B

**Adult HIV/AIDS Confidential Case Report Form**

*(Patients ≥13 years of age at time of diagnosis)*

<table>
<thead>
<tr>
<th>Date of HIV test</th>
<th>Surveillance Method</th>
<th>Source</th>
<th>STATE #</th>
<th>HARMS #</th>
<th>WEEK</th>
<th>YEAR</th>
<th>P</th>
<th>LN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **PATIENT IDENTIFIER INFORMATION**

   - MR #: __________
   - SSN #: __________

   **Patient Name:**
   - (LAST, FIRST, MI): __________

   **Address:**
   - City: __________
   - County: __________
   - State: __________
   - Zip: __________

2. **PROVIDER INFORMATION**

   **Provider's Name:**
   - __________

   **Facility:**
   - __________

   **City:**
   - __________

   **State:**
   - __________

   **Zip:**
   - __________

3. **FORM INFORMATION**

   **Date Completed:** __________

   **Person reporting:**
   - __________

4. **DEMOGRAPHIC INFORMATION**

   **Diagnostic Status:**
   - HIV Infection
   - AIDS

   **Date of Birth:**
   - __________

   **Current Status:**
   - Alive
   - Dead
   - Unk

   **Date of Death:**
   - __________

   **State/Terr Death:**
   - __________

   **Sex:**
   - Male
   - Female

   **Ethnicity:**
   - Hispanic/Latino
   - Unk
   - Not Hispanic or Latino

   **Race:**
   - Black or African Am
   - White
   - Asian
   - American Indian/Alaskan Native
   - Native Hawaiian or Other Pacific Islander
   - Unk

   **Country of Birth:**
   - US
   - Other

   **Residence at Diagnosis:**
   - Same as CURRENT address
   - __________

   **City:**
   - __________

   **County:**
   - __________

   **State:**
   - __________

   **Zip:**
   - __________

5. **FACILITY OF DIAGNOSIS**

   **Facility Name:**
   - __________

   **City:**
   - __________

   **State/Country:**
   - __________

   **Identification Method:**
   - Lab Report
   - Lab Audit
   - ICD-9

   **Viral Load:**
   - Other

   **Report Medium:**
   - Paper, filed
   - Paper, mailed
   - Disk

   **Paper, faxed
   - Phone
   - Elec Trans

6. **RISK FACTOR HISTORY**

   **Before the 1st positive HIV test, this patient had:**
   - (check all that apply)
     - Sex with male
     - Sex with female
     - Injected drugs
     - Rec’d clotting factor

   **HETEROsexual relations with the following:**
   - IDU
   - Sexual male (applies to females only)
   - Person with hemophilia
   - Coagulation disorder
   - Transfusion recipient w/ documented HIV infection
   - Person with AIDS or documented HIV infection, risk unspecified
   - Person w/ AIDS or documented HIV infection, risk unspecified

   **Received transfusion Date 1**: __________

   **Date last received transfusion**: __________

   **Received transplant**: __________

   **Worked in health-care or clinical lab setting**: __________

   **NO IDENTIFIED RISK (NIR)**

7. **HIV TESTING AND TREATMENT HISTORY**

   **Source:**
   - Patient Interview
   - Chart abstraction
   - Provider Report
   - PEMS
   - Other

   **Date patient answered questions:** __________

   **Ever had a previous positive HIV test?**
   - Yes
   - No
   - Refused
   - Unkn

   **Date of first positive HIV test:** __________

   **Has the patient ever had a negative HIV test?**
   - Yes
   - No
   - Refused
   - Unkn

   **Date of the last negative HIV test:** __________

   **Number of negative HIV tests in the past 2 years:** __________

   **Did the patient ever use antiretrovirals to treat/prevent HIV or HBV?**
   - Yes
   - No
   - Unkn

   **If ‘YES’, list medications here:**

   **First date of ARV use:** __________

   **Date of last ARV use:** __________

   **Has the patient received PCP prophylaxis?**
   - Yes
   - No
   - Unkn

   **Why was the patient tested for HIV?**
   - Routine test
   - Rule out HIV
   - Symptoms/Dx w/ Ol
   - Partner dx w/ HIV
   - ‘Just checking’
   - Regular tester
   - Other: __________

---

9
8. LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS:
(Indicate FIRST test)

<table>
<thead>
<tr>
<th>RESULT</th>
<th>TEST DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pos</td>
<td>Neg</td>
</tr>
<tr>
<td>HIV-1 EIA</td>
<td>1</td>
</tr>
<tr>
<td>HIV1/HIV2 EIA</td>
<td>1</td>
</tr>
<tr>
<td>HIV1 Western Blot</td>
<td>1</td>
</tr>
<tr>
<td>Other HIV Ab Test</td>
<td>1</td>
</tr>
</tbody>
</table>

SPECIMEN TYPE: Oral Fluid Serum

VIRAL LOAD TEST: (Record EARLIEST & MOST RECENT)

<table>
<thead>
<tr>
<th>Test Type</th>
<th>COPIES/mL</th>
<th>Mo</th>
<th>Day</th>
<th>Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 NASBA</td>
<td>1</td>
<td>20</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>12 RT-PCR (GT)</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 bDNA (V2)</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of 1st Resistance Test: Lab:

IMMUNOLOGIC LAB TESTS:

<table>
<thead>
<tr>
<th>Closest to current diagnostic status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo Day Yr</td>
</tr>
<tr>
<td>CD4 count _____ cells/ul (%)</td>
</tr>
<tr>
<td>CD4 count _____ cells/ul (%)</td>
</tr>
</tbody>
</table>

FIRST <200 or <14% of total lymphocytes:

| CD4 count _____ cells/ul (%) |
| CD4 count _____ cells/ul (%) |

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not available, is HIV diagnosis documented by a physician? Yes No Unk

If ‘YES’, provide date of physician documentation:

TB/HIV co-infection is reportable!

Date of last tuberculin skin test:  ____  ____

Results: □ Pos □ Neg □ Not done

9. CLINICAL STATUS

(check one)

Clinical Record Reviewed?
□ YES □ NO

AIDS INDICATOR DISEASES:

- Candidiasis, bronch, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- HIV encephalopathy
- Hepatitis simplex, chronic ulcers, or bronchi, pneumonitis or esophagitis
- Histoplasmosis, diss. or extrapulmonary
- Isosporiasis, chronic intestinal
- Kaposis sarcoma
- Lymphoma, Burkitts (or equivalent)
- Lymphoma, immunoblastic (or equivalent)
- Lymphoma, primary in brain
- Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary
- M. tuberculosis, pulmonary
- M. tuberculosis, diss. or extrapulmonary
- Mycobacterium of other or unidentified species, diss. or extrapulmonary
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent
- Progressive multifocal leukoencephalopathy
- Salmonella septicaemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

10. TREATMENT/SERVICES REFERRAL

Patient informed of his/her infection? □ YES □ NO □ UNKN

This patient’s partners will be notified about their HIV exposure and counseled by:
□ Physician/provider □ Patient □ Unknown

Health care providers can request assistance for notification of potentially exposed partners. Would you like this assistance from DPH?

□ YES PLEASE □ NO THANKS

Is patient enrolled in a clinical trial?
If ‘YES’, name:

Is patient receiving or been referred for:

- HIV related medical services:
- Substance abuse treatment services:

11. FOR WOMEN

Is patient receiving or been referred for OB/GYN services?
□ Y □ N □ U

Is this patient currently pregnant?
□ Y □ N □ U

Has the patient delivered any infants?
□ Y □ N □ U

If ‘YES’, when is the due date?

If ‘YES’, child’s date of birth:

Hospital of birth:

City: _______ State: _______
APPENDIX C

STATE OF CONNECTICUT
Dr. Katherine A. Kelley Public Health Laboratory
Connecticut Department of Public Health
395 West Street
Rocky Hill, CT 06067

April 20, 2015

To: Users of Connecticut Department of Public Health (CTDPH) HIV Laboratory Testing Services.

Effective April 27, 2015, the Dr. Katherine A. Kelley Public Health Laboratory will implement a new HIV laboratory testing algorithm based on updated recommendations issued by the Centers for Disease Control and Prevention (Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations). The recommended algorithm has several advantages over previous recommendations, including more accurate laboratory diagnosis of acute HIV-1 infection, equally accurate laboratory diagnosis of established HIV-1 infection, and more accurate laboratory diagnosis of HIV-2 infection, fewer indeterminate results, and faster turnaround time for most test results. Briefly, this test algorithm will include initial testing with an FDA-approved antigen/antibody combination (4th generation) enzyme immunoassay (Genetic Systems HIV-1/HIV-2 Ag/Ab Combo EIA) followed by an antibody differentiation test (the Multiplex HIV-1/HIV-2 Rapid Test that can differentiate HIV-1 from HIV-2 antibodies) that is performed when the initial 4th generation EIA is repeatedly reactive. HIV-1 Nucleic Acid testing (HIV-1 NAT) will also be available as a send-out referral test when indicated (e.g. initial 4th generation EIA is repeatedly reactive/Multiplex negative or indeterminate). Since the 4th generation antigen/antibody combo EIA detects HIV-1 p24 antigen, in addition to HIV-1 and HIV-2 antibody, the updated algorithm, also utilizing the HIV-1 NAT when indicated, will allow detection of HIV infection earlier during seroconversion.

Please note the following changes associated with the implementation of the updated HIV test algorithm:

- Testing of oral fluid specimens (Orasure® HIV-1 Oral Specimen Collection Device) will be discontinued as of June 1, 2015. One tube of whole blood, serum or plasma will be the only specimens accepted for testing. Please submit a separate second tube when requesting multiple additional tests (e.g. Syphilis Serology and HCV Antibody). After specimen collection, refrigerate specimens at 2-8°C prior to shipment to the laboratory. Specimens should be received by the laboratory within 7 days of collection.

- HIV-1 Western blot testing is no longer part of the recommended algorithm and will be discontinued. Supplemental testing will be performed using the Multiplex HIV-1/HIV-2 Rapid Test.

- Since no further testing is required for specimens that are nonreactive on the initial 4th generation EIA, supplemental testing with the Multiplex HIV-1/HIV-2 Rapid Test will only be performed when the initial 4th generation EIA is found to be repeatedly reactive (presumptive positive) by the CTDPH laboratory.

Please call 860-920-6662 with any questions or concerns as needed.

Sincerely,

Anthony Musombwe, PhD, HCLD (ABB)
Bioscience Laboratory Division Director
Dr. Katherine A. Kelley Public Health Laboratory
Connecticut Department of Public Health
395 West Street
Rocky Hill, CT 06067
E-mail: anthony.musombwe@ct.gov
If you have any questions regarding the reporting of HIV positives cases to the CT DPH, please contact:

**OTL Forms:**

Susan Major, OTL Quality Improvement (QI) Coordinator  
Tel: 860-509-7821  
Email: susan.major@ct.gov

**Routine Testing Forms (ETI Programs):**

Dulce Dones-Mendez, Expanded Testing Initiative (ETI) Coordinator  
Tel: 860-509-8054  
Email: dulce.dones-mendez@ct.gov