

# MCAP INFANT HIV TEST RESULTS FORM

Patient Name: \_\_\_\_\_

Patient ID Number:

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Mother's ID Number:

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## 1. Initial HIV Testing (recommended at 6-12 weeks of age)

HIV Test Results:

Positive  Negative  Inconclusive

Date of HIV Test:

		/			/				
day			month			year			

Method of HIV Testing:

BDNA

P24 Antigen

DNA PCR

Other: \_\_\_\_\_

RNA PCR

## 2. Additional Infant HIV Testing

Additional Test 1 Reason:

Confirmatory HIV Testing  Clinical Indication  Final HIV Testing

HIV Test Results:

Positive  Negative  Inconclusive

Date of HIV Test:

		/			/				
day			month			year			

Method of HIV Testing:

Elisa

BDNA

RNA PCR

Western Blot

DNA PCR

P24 Antigen

HIV Rapid Test

Other: \_\_\_\_\_

Additional Test 2 Reason:

Confirmatory HIV Testing  Clinical Indication  Final HIV Testing

HIV Test Results:

Positive  Negative  Inconclusive

Date of HIV Test:

		/			/				
day			month			year			

Method of HIV Testing:

Elisa

BDNA

RNA PCR

Western Blot

DNA PCR

P24 Antigen

HIV Rapid Test

Other: \_\_\_\_\_

Additional Test 3 Reason:

Confirmatory HIV Testing  Clinical Indication  Final HIV Testing

HIV Test Results:

Positive  Negative  Inconclusive

Date of HIV Test:

		/			/				
day			month			year			

Method of HIV Testing:

Elisa

BDNA

RNA PCR

Western Blot

DNA PCR

P24 Antigen

HIV Rapid Test

Other: \_\_\_\_\_

## 3. Final HIV status of infant determined to be:

Positive  Negative

Date of Determination of  
Final HIV Status:

		/			/				
day			month			year			

↳ **If negative, complete Program Discontinuation Form**