

**Patient Identification**

*Patient Name	*First Name	*Middle Name	*Last Name	Last Name Soundex
*Alternate Name Type (ex Alias, Married)		*First Name	*Middle Name	*Last Name
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary		*Current Street Address		*Phone ( ) _____
City	County	State/Country	*ZIP Code	
*Medical Record Number		*Other ID Type: _____ Number: _____		

**Adult HIV Confidential Case Report Form**(Patients  $\geq$ 13 Years of Age at Time of Diagnosis) \* Information NOT transmitted to CDC**Health Department Use Only**

Date Received at Health Department ____/____/____	eHARS Document UID _____	State Number _____
Reporting Health Dept - City / County		City/County Number
Document Source _____	Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Report Medium <input type="checkbox"/> 1-Field Visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic Transfer <input type="checkbox"/> 6-CD/Disk	

**Facility Providing Information (record all dates as mm/dd/yyyy)**

Facility Name		*Phone ( ) _____	
*Street Address			
City	County	State/Country	Zip Code
Facility Type	<u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<u>Outpatient:</u> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____	<u>Screening, Diagnostic, Referral</u> <u>Agency:</u> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____
		<u>Other Facility:</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
Date Form Completed ____/____/____	*Person Completing Form	*Phone ( ) _____	

**Patient Demographics (record all dates as mm/dd/yyyy)**

Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/ US Dependency (please specify) _____		
Date of Birth ____/____/____	Alias Date of Birth ____/____/____		
Vital Status <input type="checkbox"/> 1- Alive <input type="checkbox"/> 2- Dead	Date of Death ____/____/____	State of Death _____	
Current Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male-to-Female (MTF) <input type="checkbox"/> Transgender Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional gender identity (specify) _____		
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	*Expanded Ethnicity _____		
Race (check all that apply)	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		*Expanded Race _____

**Residence at Diagnosis (add additional addresses in Comments)**

Address Type (Check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at AIDS diagnosis <input type="checkbox"/> Check if <u>SAME</u> as Current Address			
*Street Address			
City	County	State/Country	*ZIP Code

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

## STATE/LOCAL USE ONLY

– Patient identifier information is not transmitted to CDC! –

Physician's Name: (Last, First, M.I.) \_\_\_\_\_

Medical Record

Phone No: ( ) \_\_\_\_\_

No. \_\_\_\_\_

Hospital/Facility: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Phone No: ( ) \_\_\_\_\_

## Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type  HIV  AIDS (check all that apply to facility below)  Check if SAME as Facility Providing Information

Facility Name \_\_\_\_\_

\*Phone ( ) \_\_\_\_\_

\*Street Address \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

State/Country \_\_\_\_\_

Zip Code \_\_\_\_\_

Facility Type Inpatient:  Hospital Outpatient:  Private Physician's Office Screening, Diagnostic, Referral Agency: Other Facility:  Emergency Room  
 Other, specify \_\_\_\_\_  Adult HIV Clinic  CTS  STD Clinic  Laboratory  Corrections  Unknown  
 Other, specify \_\_\_\_\_  Other, specify \_\_\_\_\_  Other, specify \_\_\_\_\_

\*Provider Name \_\_\_\_\_

\*Provider Phone ( ) \_\_\_\_\_

\*Specialty \_\_\_\_\_

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)  Pediatric risk (please enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with male  Yes  No  UnknownSex with female  Yes  No  UnknownInjected non-prescription drugs  Yes  No  Unknown

Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: \_\_\_\_\_  
 Date received (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  Unknown

## HETEROSEXUAL relations with any of the following:

HETEROSEXUAL contact with intravenous/injection drug user  Yes  No  UnknownHETEROSEXUAL contact with bisexual male  Yes  No  UnknownHETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with transfusion recipient with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with transplant recipient with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with person with AIDS or documented HIV Infection, risk not specified  Yes  No  Unknown

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)  
 First date received \_\_\_\_/\_\_\_\_/\_\_\_\_ Last date received \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  Unknown

Received transplant of tissue/organs or artificial insemination  Yes  No  Unknown

Worked in a healthcare or clinical laboratory setting  Yes  No  Unknown  
 If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: \_\_\_\_\_

Other documented risk (please include detail in Comments section)  Yes  No  Unknown

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: (PRA (0920-0573)). **Do not send the completed form to this address.**

**Laboratory Data (record additional tests in Comments section)**

**HIV Antibody Tests (Non-type differentiating) [HIV-1 vs. HIV-2]**

**TEST 1:**  HIV-1 EIA  HIV-1/2 EIA  HIV-1/2 Ag/Ab  HIV-1 WB  HIV-1 IFA  HIV-2 EIA  HIV-2 WB  Other: Specify Test: \_\_\_\_\_

**RESULT:**  Positive/Reactive  Negative/Nonreactive  Indeterminate **RAPID TEST (check if rapid):**  **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**TEST 2:**  HIV-1 EIA  HIV-1/2 EIA  HIV-1/2 Ag/Ab  HIV-1 WB  HIV-1 IFA  HIV-2 EIA  HIV-2 WB  Other: Specify Test: \_\_\_\_\_

**RESULT:**  Positive/Reactive  Negative/Nonreactive  Indeterminate **RAPID TEST (check if rapid):**  **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIV Antibody Tests (Type differentiating) [HIV-1 vs. HIV-2]**

**TEST:**  HIV-1/2 Differentiating (e.g., Multispot)

**RESULT:**  HIV-1  HIV-2  Both (undifferentiated)  Neither (negative) **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIV Detection Tests (Qualitative)**

**TEST 1:**  HIV-1 RNA/DNA NAAT (Qual)  HIV-1 P24 Antigen  HIV-1 Culture  HIV-2 RNA/DNA NAAT (Qual)  HIV-2 Culture

**RESULT:**  Positive/Reactive  Negative/Nonreactive  Indeterminate **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**TEST 2:**  HIV-1 RNA/DNA NAAT (Qual)  HIV-1 P24 Antigen  HIV-1 Culture  HIV-2 RNA/DNA NAAT (Qual)  HIV-2 Culture

**RESULT:**  Positive/Reactive  Negative/Nonreactive  Indeterminate **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIV Detection Tests (Quantitative viral load) Note: Include earliest test after diagnosis**

**TEST 1:**  HIV-1 RNA/DNA NAAT (Quantitative viral load)

**RESULT:**  Detectable  Undetectable **Copies/mL:** \_\_\_\_\_ **Log:** \_\_\_\_\_ **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**TEST 2:**  HIV-1 RNA/DNA NAAT (Quantitative viral load)

**RESULT:**  Detectable  Undetectable **Copies/mL:** \_\_\_\_\_ **Log:** \_\_\_\_\_ **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Immunologic Tests (CD4 count and percentage)**

**CD4 at or closest to current diagnostic status: CD4 count:** \_\_\_\_\_ cells/ $\mu$ L **CD4 percentage:** \_\_\_\_% **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**First CD4 result <200 cells/ $\mu$ L or <14%: CD4 count:** \_\_\_\_\_ cells/ $\mu$ L **CD4 percentage:** \_\_\_\_% **Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Documentation of Tests**

Date of last documented negative HIV test: \_\_\_\_/\_\_\_\_/\_\_\_\_

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?  
 Yes  No  Unknown

Specify type of test: \_\_\_\_\_

If YES, provide date of documentation by physician: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Clinical (select D for Definitive or P for Presumptive where applicable) (record all dates as mm/dd/yyyy)**

	D	P	Date		D	P	Date		D	P	Date
Candidiasis, bronchi, trachea, or lungs				Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				M. tuberculosis, pulmonary†			
Candidiasis, esophageal				Histoplasmosis, disseminated or extrapulmonary				M. tuberculosis, disseminated or extrapulmonary†			
Carcinoma, invasive cervical				Isosporiasis, chronic intestinal (>1 mo. duration)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
Coccidioidomycosis, disseminated or extrapulmonary				Kaposi's sarcoma				Pneumocystis pneumonia			
Cryptococcosis, extrapulmonary				Lymphoma, Burkitt's (or equivalent)				Pneumonia, recurrent, in 12 mo. period			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				Lymphoma, immunoblastic (or equivalent)				Progressive multifocal leukoencephalopathy			
Cytomegalovirus disease (other than in liver, spleen, or nodes)				Lymphoma, primary in brain				Salmonella septicemia, recurrent			
Cytomegalovirus retinitis (with loss of vision)				Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary				Toxoplasmosis of brain, onset at >1 mo. of age			
HIV encephalopathy								Wasting syndrome due to HIV			

†If TB selected above, indicate RVCT Case Number:

**Treatment/Services Referrals (record all dates as mm/dd/yyyy)**

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> 1-Health Dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown		
<b>For Female Patient</b>			
This patient is receiving or has been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Has this patient delivered live-born infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>For Children of Patient (record most recent birth in these boxes; record additional or multiple births in the Comments section)</b>			
*Child's Name	Child Soundex	Child's Date of Birth	
*Child's Coded ID	Child's State Number		
Hospital of Birth (if child was born at home, enter "home birth" for hospital name)			
Hospital Name	*Phone	*Zip Code	
*Street Address	City	County	State/Country

**HIV Testing and Antiretroviral Use History (if required by Health Department) (record all dates as mm/dd/yyyy)**

Main source of testing and treatment history information (select one) <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other	Date patient reported information ____/____/____	
Ever had previous positive HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of first positive HIV test ____/____/____	
Ever had a negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of last negative HIV test (If date is from a lab test with test type, enter in Lab Data section) ____/____/____	
Number of negative HIV tests within 24 months before first positive test # _____ <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown		
Ever taken any antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	If Yes, ARV medications:	
Dates ARVs taken	Date first began: ____/____/____	Date of last use: ____/____/____

**\*Comments**

**\*Local / Optional Fields**