



Adult HIV/AIDS Confidential Case Report Form

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

DPH USE ONLY

Date of + HIV test to be used for TTH / /20__	Surveillance Method <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> F <input type="checkbox"/> U	Report Source	STATE #	HARMS #	WEEK	YEAR 20__	Partial
--	--	---------------	---------	---------	------	--------------	---------

1. PATIENT IDENTIFIER INFORMATION

MR or ID # _____

Patient Name: _____ Phone: () - _____
(LAST, FIRST, MI)

Address: _____ City: _____ County: _____ State: _____ Zip: _____

2. PROVIDER INFORMATION

Provider's Name: _____ Phone: () - _____

Facility: _____ City: _____ State: _____ Zip: _____

3. FORM INFORMATION

Date Completed: ___/___/___ Person reporting: _____ Phone: () - _____

4. DEMOGRAPHIC INFORMATION

Diagnostic Status: <input type="checkbox"/> HIV Infection <input type="checkbox"/> AIDS	Date of Birth: ___/___/___	Current Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Date of Death: ___/___/___	State/Terr Death: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: (select one) <input type="checkbox"/> Hisp/Latino <input type="checkbox"/> Unk <input type="checkbox"/> Not Hispanic or Latino	Race: (select one or more) <input type="checkbox"/> Black or African Am <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unk		Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk
Residence at Diagnosis: <input type="checkbox"/> Same as CURRENT address City: _____ County: FFLD HTFD LITCH NH NL MDX TLND WIND State: _____ Zip: _____				

5. FACILITY OF DIAGNOSIS

Facility Name: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> _____
City: _____
State/Country: _____
Identification Method: <input type="checkbox"/> Lab Report <input type="checkbox"/> Lab Audit <input type="checkbox"/> ICD-9 <input type="checkbox"/> Viral Load <input type="checkbox"/> URS <input type="checkbox"/> Unknown
Report Medium: <input type="checkbox"/> Paper, field <input type="checkbox"/> Paper, mailed <input type="checkbox"/> Disk <input type="checkbox"/> Paper, faxed <input type="checkbox"/> Phoned <input type="checkbox"/> Elec Trans

6. RISK FACTOR HISTORY

Before the 1 st positive HIV test/AIDS diagnosis, patient had: (check all that apply)	Y	N	U
• Sex with male			
• Sex with female			
• Injected drugs			
• Rec'd clotting factor			
HETEROsexual relations with the following:			
• IDU			
• Bisexual 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			
Received transfusion Date 1 st : _____ Date last: _____			
Received transplant			
Worked in health-care or clinical lab setting			
NO IDENTIFIED RISK (NIR)			

7. HIV TESTING AND TREATMENT HISTORY N/A

Date patient answered questions: ___/___/___
Date of first positive HIV test: ___/___/___
Has the patient <u>EVER</u> had a <i>negative</i> HIV test? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN
Date of the <u>LAST</u> negative HIV test: ___/___/___
Number of HIV tests in the past 2 years: 1 (first positive) + _____ (# prior tests) = _____

Did the patient ever use antiretrovirals to treat/prevent HIV or HBV? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN
If 'YES', list medications here: _____
First date of ARV use: ___/___/___
Still taking ARVS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN
If 'NO': LAST DATE of ARV use: ___/___/___
Has the patient received PCP prophylaxis?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN
Why was the patient tested for HIV? <input type="checkbox"/> Routine test <input type="checkbox"/> Rule out HIV <input type="checkbox"/> Symptoms/Dx w/ OI <input type="checkbox"/> Partner dx w/ HIV <input type="checkbox"/> 'Just checking' <input type="checkbox"/> Regular tester <input type="checkbox"/> Other: _____

8. LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate <u>FIRST</u> test)					
	RESULT		TEST DATE		
	Pos	Neg	Mo	Day	Yr
HIV-1 EIA	1	0			
HIV1/HIV2 EIA	1	0			
HIV1 Western Blot	1	0			
Other HIV Ab Test	1	0			
SPECIMEN TYPE:	Oral Fluid		Serum		
VIRAL LOAD TEST: (Record EARLIEST & MOST RECENT)					
Test Type:	COPIES/mL:		Mo	Day	Yr
11 NASBA					
12 RT-PCR (ST)					
12 RT-PCR (UL)					
13 bDNA (V2)					
13 bDNA (V3)					
Date of 1st Resistance Test:	Lab:				

IMMUNOLOGIC LAB TESTS:			
Closest to current diagnostic status:	Mo	Day	Yr
CD4 count _____ cells/ul (____%)			
CD4 count _____ cells/ul (____%)			
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:	Mo	Day	Yr

TB/HIV co-infection is reportable!

Date of last tuberculin skin test: _____/_____/_____

Results: Pos Neg Not done

9. CLINICAL STATUS

Clinical Record Reviewed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
AIDS INDICATOR DISEASES:			
Candidiasis, bronchi, trachea, or lungs	___/___/___		<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___		<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal	___/___/___		<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___		<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___		<input type="checkbox"/>
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___		<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___		<input type="checkbox"/>
Isosporiasis, chronic intestinal	___/___/___		<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___		<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___		<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___		<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV	___/___/___		<input type="checkbox"/>

10. TREATMENT/SERVICES REFERRAL

Patient informed of his/her infection? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN			
This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown	This patient's medical treatment is primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private insurance/HMO <input type="checkbox"/> No coverage <input type="checkbox"/> Other public funding <input type="checkbox"/> Clinic trial/program <input type="checkbox"/> Unknown		
	<p>Health care providers can request assistance for notification of potentially exposed partners. Would you like this assistance from DPH?</p> <input type="checkbox"/> YES PLEASE <input type="checkbox"/> NO THANKS		
Is patient enrolled in a clinical trial? If 'YES', name: _____	Yes	No	Unk
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?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Is this patient currently pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Has the patient delivered any infants?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
If 'YES', child's date of birth:	___/___/___
Hospital of birth:	_____
City:	_____ State: _____

12. COMMENTS: _____