



# 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	Surv Method	Report Source	STATE #	HARMS #	WEEK	YEAR
/ /200__	<input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> U					200__

**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**

<b>Diagnostic Status:</b> 1 HIV Infection (not AIDS) 2 AIDS	<b>Date of Birth:</b> ___/___/___	<b>Current Status:</b> 1 Alive 2 Dead 9 Unk	<b>Date of Death:</b> ___/___/___	<b>State/Terr Death:</b> _____
<b>Sex:</b> 1 Male 2 Female	<b>Ethnicity:</b> (select one) 1 Hisp/Latino 9 Unk 2 Not Hispanic or Latino	<b>Race:</b> (select one or more) 1 Black or African Am 2 White 3 Asian 4 American Indian/Alaskan Native 5 Native Hawaiian or Other Pacific Islander 9 Unk	<b>Country of Birth:</b> 1 US 7 US Depen/Possessions, incl. PR 8 Other _____ 9 Unk	
<b>Residence at Diagnosis:</b> <input type="checkbox"/> Same as CURRENT address				
<b>City:</b> _____ <b>County:</b> FFLD HTFD LITCH NH NL MDX TLND WIND <b>State:</b> _____ <b>Zip:</b> _____				

**5. FACILITY OF DIAGNOSIS**

<b>Facility Name:</b>  <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> _____
<b>City:</b> _____
<b>State/Country:</b> _____
<b>Identification Method:</b> <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
<b>Report Medium:</b> <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. PATIENT HISTORY**

Before the 1 <sup>st</sup> 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			
<b>HETEROsexual relations with the following:</b>			
• 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 <sup>st</sup> : _____ Date last: _____			
Received transplant			
Worked in health-care or clinical lab setting			
<b>NO IDENTIFIED RISK (NIR)</b>			

**7. HIV TESTING AND TREATMENT HISTORY**  N/A

Date patient answered questions: ___/___/___
<b>DATE OF FIRST POSITIVE HIV TEST</b>
Date (month/year): ___/___
<b>DATE OF LAST NEGATIVE HIV TEST</b>
Date (month/year): ___/___
<b>PRIOR HIV TESTS</b>
Number of HIV tests in 2 yrs before the 1 <sup>st</sup> positive: <b>1 (first positive) + _____ (# prior tests) = _____</b>

<b>Did the patient ever use antiretrovirals to treat/prevent HIV or HBV?</b> <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: ___/___/___
<b>Has patient received PCP prophylaxis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKN
<b>Why was the patient tested for HIV?</b> <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			
<b>SPECIMEN TYPE:</b>	Oral Fluid		Serum		
<b>VIRAL LOAD TEST: (Record EARLIEST &amp; MOST RECENT)</b>					
Test Type:	COPIES/mL:		Mo	Day	Yr
11 NASBA					
12 RT-PCR (ST)					
12 RT-PCR (UL)					
13 bDNA (V2)					
13 bDNA (V3)					
<b>Date of 1<sup>st</sup> Resistance Test:</b>	<b>Lab:</b>				

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
<b>TB/HIV co-infection is reportable!</b>			
Date of last tuberculin skin test:	____/____/____		
Results:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done		

**9. CLINICAL STATUS**

Clinical Record Reviewed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
<b>AIDS INDICATOR DISEASES:</b>			
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:		This patient's medical treatment is primarily reimbursed by:	
<input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown		<input type="checkbox"/> Medicaid/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	
<b>Health care providers can request assistance for notification of potentially exposed partners. Would you like this assistance from DPH?</b>		Yes	No
<input type="checkbox"/> YES PLEASE <input type="checkbox"/> 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?	<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:** \_\_\_\_\_