

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:	

U.S. Department of Health
& Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control
and Prevention**Health Department Use Only**

Form approved OMB no 0920-0573 Exp. 02/29/2016

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	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____
		<i>Other Facility:</i> <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 as Current Address</u>			
*Street Address			
City	County	State/Country	*ZIP Code

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.**

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

Medical Record

Phone No: ()

No. _____

Hospital/Facility:

Person Completing Form:

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
 Other, specify _____Outpatient: Private Physician's Office
 Adult HIV Clinic
 Other, specify _____Screening, Diagnostic, Referral Agency:
 CTS STD Clinic
 Other, specify _____Other Facility: Emergency Room
 Laboratory Corrections Unknown
 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 Unknown

Sex with female

 Yes No Unknown

Injected non-prescription drugs

 Yes No UnknownReceived clotting factor for hemophilia/
coagulation disorderSpecify 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 Unknown

HETEROSEXUAL contact with bisexual male

 Yes No Unknown

HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with transfusion recipient with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with transplant recipient with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with person with documented HIV infection, risk not specified

 Yes No Unknown

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)

 Yes No Unknown

First date received ___/___/_____ Last date received ___/___/_____

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

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. Information in CDC's National HIV 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).

Laboratory Data (record additional tests in Comments section) (record all dates as mm/dd/yyyy)

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

TEST 1: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

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

Manufacturer: _____

TEST 2: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

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

Manufacturer: _____

TEST 3: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

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

Manufacturer: _____

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) Indeterminate **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 at or 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/ μ L **CD4 percentage:** _____% **Collection Date:** ___/___/_____

First CD4 result <200 cells/ μ L or <14%: CD4 count: _____ cells/ μ L **CD4 percentage:** _____% **Collection Date:** ___/___/_____

Other CD4 result: CD4 count: _____ cells/ μ L **CD4 percentage:** _____% **Collection Date:** ___/___/_____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? Yes No Unknown

If YES, provide date (specimen collection date if known) of earliest positive test for this algorithm: ___/___/_____

Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]:

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

If YES, provide date of diagnosis: ___/___/_____

Date of last documented negative HIV test (before HIV diagnosis date): ___/___/_____ Specify type of test: _____

Clinical (record all dates as mm/dd/yyyy)

Diagnosis	OIs	Date	Diagnosis	OIs	Date	Diagnosis	OIs	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/undefined 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:

