**Note on using the modifiable version of the form:**

If changes are made to the form, please remove the OMB approval number, OMB expiration date, CDC form number, and CDC revision date. A notation that the form is adapted from the relevant CDC form number and revision date can be included.

# I. Patient Identification (record all dates as mm/dd/yyyy)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*First Name** | | **\*Middle Name** | | | | | **\*Last Name** | | **Last Name Soundex** | |
| **Alternate Name Type** (ex: Alias, Married) | | | **\*First Name** | | | | **\*Middle Name** | **\*Last Name** | | |
| **Address Type** □ Residential □ Bad address □ Correctional facility  □ Foster home **□** Homeless **□** Military **□** Other  **□** Postal **□** Shelter **□** Temporary | | | | | | **\*Current Address, Street** | | | | **Address Date**  / / |
| **\*Phone**  ( ) | **City** | | | **County** | | | **State/Country** | | **\*ZIP Code** | |
| **\*Medical Record Number** | | | | | **\*Other ID Type \*Number** | | | | | |

|  |  |  |
| --- | --- | --- |
| **U.S. Department of Health and Human Services** | **Adult HIV Confidential Case Report Form** | **Centers for Disease Control and Prevention (CDC)** |
| **(Patients >13 years of age at time of diagnosis) \*Information NOT transmitted to CDC** |

**II. Health Department Use Only (record all dates as mm/dd/yyyy) Form approved OMB no.0920-0573 Exp. 02/28/2026**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Received at Health Department**  / / | **eHARS Document UID** | | **State Number** |
| **Reporting Health Dept—City/County** | | **City/County Number** | |
| **Document Source** | **Surveillance Method** □ Active □ Passive □ Follow up □ Reabstraction □ Unknown | | |
| **Did this report initiate a new case investigation?**  **□** Yes **□** No **□** Unknown | **Report Medium**  □ 1-Field visit □ 2-Mailed □ 3-Faxed □ 4-Phone □ 5-Electronic transfer □ 6-CD/disk | | |

# III. Facility Providing Information (record all dates as mm/dd/yyyy)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Facility Name** | | | | **\*Phone**  ( ) |
| **\*Street Address** | | | | |
| **City** | **County** | | **State/Country** | **\*ZIP Code** |
| **Facility** *Inpatient: Outpatient:* □ Private physician’s office *Screening, Diagnostic, Referral Agency*: *Other Facility*: □ Emergency room  **Type** □ Hospital □ Adult HIV clinic □ CTS □ STD clinic □ Laboratory □ Corrections □ Unknown  □ Other, specify □ Other, specify □ Other, specify □ Other, specify | | | | |
| **Date Form Completed**  / / | | **\*Person Completing Form** | | **\*Phone**  ( ) |

# IV. Patient Demographics (record all dates as mm/dd/yyyy)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sex Assigned at Birth □** Male **□** Female **□** Unknown | | | **Country of Birth □** US **□** Other/US dependency (specify) | | |
| **Date of Birth**  / / | | | | **Alias Date of Birth**  / / | |
| **Vital Status □** 1-Alive **□** 2-Dead | | **Date of Death** / / | | | **State of Death** |
| **Gender Identity** | **□** Man **□** Woman **□** Transgender man **□** Transgender woman  **□** Additional gender identity (specify)  □ Declined to answer **□** Unknown | | | | |
| **Date Identified** | / / | | | | |
| **Sexual Orientation** | □ Straight or heterosexual □ Lesbian or gay □ Bisexual  □ Additional sexual orientation (specify)  □ Declined to answer **□** Unknown | | | | |
| **Date Identified** | / / | | | | |
| **Ethnicity** | **□** Hispanic/Latino **□** Not Hispanic/Latino **□** Unknown | | | | **Expanded Ethnicity** |
| **Race**  (check all that apply) | **□** American Indian/Alaska Native **□** Asian **□** Black/African American **□** Native Hawaiian/Other Pacific Islander **□** White **□** Unknown | | | | **Expanded Race** |

# V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

|  |  |  |  |
| --- | --- | --- | --- |
| **Address Event Type**  (check all that apply to address below) **□** Residence at HIV diagnosis **□** Residence at stage 3 (AIDS) diagnosis **□** Check if SAME as current address | | | |
| **Address Type** □ Residential □ Bad address □ Correctional facility □ Foster home **□** Homeless **□** Military **□** Other **□** Postal **□** Shelter **□** Temporary | | | |
| **\*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.** |

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis Type** | | (check all that apply to facility below) **□** HIV **□** Stage 3 (AIDS) **□** 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** | | |

# VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy) □ Pediatric Risk (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 nonprescription drugs | | □ Yes □ No □ Unknown |
| Received clotting factor for hemophilia/coagulation disorder  Specify clotting factor: Date received / / | | □ Yes □ No □ Unknown |
| **HETEROSEXUAL relations with any of the following:** | | |
| HETEROSEXUAL contact with person who injected drugs | | □ 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) | | □ 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 (include detail in Comments) | | □ Yes □ No □ Unknown |

# VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Suspect acute HIV infection?** *If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section* | | | | | □ Yes □ No □ Unknown | |
| Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset / / | | | | | □ Yes □ No □ Unknown | |
| Other evidence suggestive of acute HIV infection? *If YES, describe:*  Date of evidence / / | | | | | □ Yes □ No □ Unknown | |
| **Opportunistic Illnesses** | | | | | | |
| **Diagnosis** | **Dx Date** | **Diagnosis** | **Dx Date** | **Diagnosis** | | **Dx Date** |
| Candidiasis, bronchi, trachea, or lungs |  | Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis |  | M. tuberculosis, pulmonary1 | |  |
| Candidiasis, esophageal |  | Histoplasmosis, disseminated or extrapulmonary |  | M. tuberculosis, disseminated or extrapulmonary1 | |  |
| 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 | |  |
| 1If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: | | | | | | |

# IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

|  |
| --- |
| **HIV Immunoassays** |
| **TEST □** HIV-1 IA **□** HIV-1/2 IA **□** HIV-1/2 Ag/Ab **□** HIV-2 IA |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result □** Positive **□** Negative **□** Indeterminate **Collection Date**  / /  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |

# IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) *(cont)*

|  |
| --- |
| **TEST □** HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab) |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result** ***Overall:***□ Reactive □ Nonreactive **Collection Date**  / /  ***Analyte results:*** HIV-1 Ag: □ Reactive □ Nonreactive HIV-1/2 Ab: □ Reactive □ Nonreactive  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab) |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result**3 ***Overall interpretation***: □ Reactive □ Nonreactive □ **Index Value** **Collection Date**  / / |
| ***Analyte results***: HIV-1 Ag: **□** Reactive **□** Nonreactive **□** Not reportable due to high Ab level **Index Value** |
| HIV-1 Ab: **□** Reactive **□** Nonreactive **□** Reactive undifferentiated **Index Value** |
| HIV-2 Ab: **□** Reactive **□** Nonreactive **□** Reactive undifferentiated **Index Value**  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab) |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result**4 ***Overall interpretation***: □ HIV positive, untypable □ HIV-1 positive with HIV-2 cross-reactivity □ HIV-2 positive with HIV-1 cross-reactivity  □ HIV negative □ HIV indeterminate □ HIV-1 indeterminate □ HIV-2 indeterminate □ HIV-1 positive □ HIV-2 positive |
| ***Analyte results***: HIV-1 Ab: **□** Positive **□** Negative **□** Indeterminate **Collection Date**  / / |
| HIV-2 Ab: **□** Positive **□** Negative **□** Indeterminate |
| **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1 WB **□** HIV-1 IFA **□** HIV-2 WB |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result □** Positive **□** Negative **□** Indeterminate **Collection Date**  / /  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **HIV Detection Tests** |
| **TEST □** HIV-1/2 RNA NAAT (Qualitative) **Lab Name**  **Test Brand Name/Manufacturer** **Provider Name**  **Facility Name** **Collection Date**  / /  **Result □** HIV-1 □HIV-2 □Both (HIV-1 and HIV-2) □HIV, not differentiated (HIV-1 or HIV-2) □Neither (negative)  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1 RNA NAAT (Qualitative and Quantitative)  **Test Brand Name/Manufacturer**  **Lab Name**  **Facility Name**  **Provider Name**  **Result *Qualitative:*** □ Reactive □ Nonreactive **Collection Date**  / /  ***Analyte results:*** HIV-1 Quantitative***:*  □** Detectable above limit **□** Detectable within limits **□** Detectable below limit  **Copies/mL** **Log**  **Testing Option (**if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1 RNA/DNA NAAT (Qualitative) **□** HIV-1 culture **□** HIV-2 RNA/DNA NAAT (Qualitative) **□** HIV-2 culture |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result □** Positive **□** Negative **□** Indeterminate **Collection Date**  / /  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **TEST □** HIV-1 RNA/DNA NAAT (Quantitative) **□** HIV-2 RNA/DNA NAAT (Quantitative) |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Result □** Detectable above limit **□** Detectable within limits **□** Detectable below limit **□** Not detected **Copies/mL** **Log**  **Collection Date**  / /  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| **Drug Resistance Tests (Genotypic)** |
| **TEST □** HIV-1 Genotype (Unspecified) **Test Brand Name/Manufacturer** |
| **Lab Name** **Facility Name** |
| **Provider Name** **Collection Date**  / / |
| **Immunologic Tests (CD4 count and percentage)** |
| **CD4 count**  cells/µL **CD4 percentage**  % **Collection Date**  / / |
| **Test Brand Name/Manufacturer** **Lab Name** |
| **Facility Name** **Provider Name** |
| **Documentation of Tests** |
| **Did documented laboratory test results meet approved HIV diagnostic algorithm criteria?** **□** Yes **□** No **□** Unknown  **If YES, provide specimen collection date of earliest positive test result for this** **algorithm** / /  *Complete the above only if none of the following were positive for* ***HIV-1****: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.* |
| **Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results?** **□** Yes **□** No **□** Unknown  **If YES, provide date of diagnosis by physician** / / |
| **Date of last documented negative HIV test** **result** (before HIV diagnosis date) / /  **Specify type of test**:  **Testing Option** (if applicable) **□** Point-of-care test by provider **□** Self-test, result directly observed by a provider2 **□** Lab test, self-collected sample |
| 2Results not directly observed by a provider should be recorded in HIV Testing History.  3Complete the overall interpretation and the analyte results.  4Always complete the overall interpretation. Complete the analyte results when available. |

# X. Treatment/Services Referrals (record all dates as mm/dd/yyyy)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has this patient been informed of his/her HIV infection?**  **□** Yes **□** No **□** Unknown | **This patient’s partners will be notified about their HIV exposure and counseled by**  **□** 1-Health dept **□** 2-Physician/Provider **□** 3-Patient **□** 9-Unknown | | | | | |
| **Evidence of receipt of HIV medical care other than laboratory test result** (select one; record additional evidence in Comments)  **□** 1-Yes, documented **□** 2-Yes, client self-report, only Date of medical visit or prescription / / | | | | | |  |
| **For Female Patient** | | | | | |  |
| **This patient is receiving or has been referred for gynecological or obstetrical services**  **□** Yes **□** No **□** Unknown | | | **Is this patient currently pregnant?**  **□** Yes **□** No **□** Unknown | | **Has this patient delivered live-born infants?**  **□** Yes **□** No **□** Unknown | |
| **For Children of Patient** (record most recent birth in these boxes; record additional or multiple births in Comments) | | | | | | |
| \***Child’s Name** | | | | **Child’s Date of Birth**  / / | | |
| **Child’s Last Name Soundex** | | | **Child’s State Number** | | | |
| **Facility Name of Birth**  (if child was born at home, enter “home birth”) | | | | | \***Phone**  ( ) | |
| **Facility Type** *Inpatient: Outpatient: Other Facility*: **□** Emergency room  **□** Hospital **□** Other, specify  **□** Corrections **□** Unknown  **□** Other, specify **□** Other, specify | | | | | | |
| \***Street Address** | | | | | \***ZIP** **Code** | |
| **City** | | **County** | | | **State/Country** | |

# XI. Antiretroviral Use History (record all dates as mm/dd/yyyy)

|  |  |
| --- | --- |
| **Main source of antiretroviral (ARV) use information** (select one)  **□** Patient interview **□** Medical record review **□** Provider report **□** NHM&E **□** Other | **Date patient reported information**  / / |
| **Ever taken any ARVs?**  Yes  No  Unknown | |
| **If yes, reason for ARV use** (select all that apply)  □ HIV Tx ARV medications Date began / / Date of last use / /  □ PrEP ARV medications Date began / / Date of last use / /  □ PEP ARV medications Date began / / Date of last use / /  □ PMTCT ARV medications Date began / / Date of last use / /  □ HBV Tx ARV medications Date began / / Date of last use / /  □ Other (specify reason)  ARV medications Date began / / Date of last use / / | |

# XII. HIV Testing History (record all dates as mm/dd/yyyy)

|  |  |  |  |
| --- | --- | --- | --- |
| **Main source of testing history information** (select one)  □Patient interview **□** Medical record review **□** Provider report **□** NHM&E **□** Other | | | **Date patient reported information**  / / |
| **Ever had previous positive HIV test result?** □ Yes □ No □ Unknown | | **Date of first positive HIV test result**  / / | |
| **Was the first positive test result from a self-test performed by the patient?** □ Yes □ No □ Unknown | | | |
| **Ever had a negative HIV test result?** □ Yes □ No □ Unknown | **Date of last negative HIV test result** *(if date is from a lab test with test type, enter in Lab Data section)*  / / | | |
| **Was the last negative test result from a self-test performed by the patient?** □ Yes □ No □ Unknown | | | |
| **Number of negative HIV test results within the 24 months before the first positive test result**  □ Unknown  **How many of these negative test results were from self-tests performed by the patient?**  □ Unknown | | | |

# XIII. Comments

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|  |

# XIV. \*Local/Optional Fields

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| --- |
|  |
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|  |

|  |
| --- |
| This report to 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, 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). |