

**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 <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 Address, Street _____ / _____ / _____	
*Phone (   ) _____	City	County	State/Country
*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 (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 06/30/2019

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 <input type="checkbox"/> Inpatient: <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	Outpatient: <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____	Screening, Diagnostic, Referral Agency: <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____	Other Facility: <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/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	Expanded Race _____		

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

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 SAME as Current Address			
*Street Address		Address Date ____ / ____ / ____	
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.**

**STATE/LOCAL USE ONLY**

\*Provider Name (Last, First, M.I.)

\*Phone (      ) \_\_\_\_\_

Hospital/Facility

**Facility of Diagnosis (add additional facilities in Comments)**Diagnosis Type (Check all that apply to facility below)  HIV  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 \_\_\_\_\_

**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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	Specify clotting factor: Date received (mm/dd/yyyy): _____ / _____ / _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**HETEROSEXUAL relations with any of the following:**

HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received _____ / _____ / _____ Last date received _____ / _____ / _____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

### HIV Immunoassays (Non-differentiating)

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

Test Brand Name/Manufacturer: \_\_\_\_\_

RESULT:  Positive/Reactive  Negative/Nonreactive  Indeterminate Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Rapid Test (check if rapid)

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

Test Brand Name/Manufacturer: \_\_\_\_\_

RESULT:  Positive/Reactive  Negative/Nonreactive  Indeterminate Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Rapid Test (check if rapid)

### HIV Immunoassays (Differentiating)

HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)

Test Brand Name/Manufacturer: \_\_\_\_\_

RESULT:  HIV-1  HIV-2  Both (undifferentiated)  Neither (negative)  Indeterminate  Rapid Test (check if rapid)

Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)

Test Brand Name/Manufacturer: \_\_\_\_\_

RESULT:  Ag reactive  Ab reactive  Both (Ag and Ab reactive)  Neither (negative)  Invalid/Indeterminate  Rapid Test (check if rapid)

Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)

Test Brand Name/Manufacturer: \_\_\_\_\_

RESULT\*: HIV-1 Ag HIV-Ab  
 Reactive  Nonreactive  Not Reported  HIV-1 Reactive  HIV-2 Reactive  Both Reactive, Undifferentiated  Both Nonreactive

Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Select one result for HIV-1 Ag and one result for HIV Ab

### HIV Detection Tests (Qualitative)

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

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

TEST 2:  HIV-1 RNA/DNA NAAT (Quantitative viral load)  HIV-2 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 diagnosis: CD4 count: \_\_\_\_\_ cells/µL CD4 percentage: \_\_\_\_ % Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First CD4 result <200 cells/µL or <14%: CD4 count: \_\_\_\_\_ cells/µL CD4 percentage: \_\_\_\_ % Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Other CD4 result: CD4 count: \_\_\_\_\_ cells/µL CD4 percentage: \_\_\_\_ % Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### 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 for this algorithm: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, 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	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, pulmonary <sup>†</sup>	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary <sup>†</sup>	
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	

<sup>†</sup>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?  
 Yes  No  UnknownThis patient's partners will be notified about their HIV exposure and counseled by:  
 1-Health Dept  2-Physician/Provider  3-Patient  9-Unknown**For Female Patient**This patient is receiving or has been referred for gynecological or obstetrical services:  
 Yes  No  UnknownIs this patient currently pregnant?  
 Yes  No  UnknownHas 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 Last Name  
SoundexChild's Date of Birth  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Child's Coded ID

Child's State Number

Facility Name of Birth (if child was born at home, enter "home birth")

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

Facility Type

*Inpatient:* Hospital  
 Other, specify \_\_\_\_\_*Outpatient:* Other, specify \_\_\_\_\_*Other Facility:* Emergency Room  
 Corrections  
 Other, specify \_\_\_\_\_

\*ZIP Code

\*Street Address

City

County

State/Country

**HIV 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  OtherDate 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 \_\_\_\_\_

ARV medications: \_\_\_\_\_

Date began: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of last use: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**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  OtherDate patient reported information  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_Ever had previous positive HIV test?  Yes  No  Unknown

Date of first positive HIV test \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Ever had a negative HIV test?  Yes  No  UnknownDate 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 # \_\_\_\_\_  Unknown**Comments****\*Local/Optional Fields**