

**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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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**  
(Patients ≥13 years of age at time of diagnosis) \*Information NOT transmitted to CDCCenters for Disease Control  
and Prevention (CDC)**Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 11/30/2022

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		<u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<u>Outpatient:</u> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> Other, specify _____		<u>Screening, Diagnostic, Referral Agency:</u> <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Other, specify _____		<u>Other Facility:</u> <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 Event Type (check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Check if <u>SAME</u> as current address							
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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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.**

**STATE/LOCAL USE ONLY**

*Provider Name (Last, First, M.I.)	*Phone (     )
Hospital/Facility	

**Facility of Diagnosis (add additional facilities in Comments)**

<b>Diagnosis Type</b> (check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Check if <u>SAME</u> as facility providing information			
Facility Name			*Phone (     )
*Street Address			
City	County	State/Country	*ZIP Code
<b>Facility Type</b> <i>Inpatient:</i> <input type="checkbox"/> Hospital <i>Outpatient:</i> <input type="checkbox"/> Private physician's office <i>Screening, Diagnostic, Referral Agency:</i> <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> 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)**

<b>After 1977 and before the earliest known diagnosis of HIV infection, this patient had:</b>	
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 nonprescription 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 ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>HETEROSEXUAL relations with any of the following:</b>	
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) First date received ___/___/_____ Last date received ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other documented risk (please include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

<b>Suspect acute HIV infection?</b> <i>If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other evidence suggestive of acute HIV infection? <i>If YES, please describe:</i> Date of evidence ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>Opportunistic Illnesses</b>					
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>1</sup>	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary <sup>1</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>1</sup>If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

**Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)****HIV Immunoassays (Nondifferentiating)**

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 \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

Result  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test  
 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 \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

Result  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test  
**HIV Immunoassays (Differentiating)**  
 HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)  
 Role of test in diagnostic algorithm  
 Screening/initial test  Confirmatory/supplemental test  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

Result<sup>1</sup> Overall interpretation:  HIV-1 positive  HIV-2 positive  HIV positive, untypable  HIV-2 positive with HIV-1 cross-reactivity  
 HIV-1 indeterminate  HIV-2 indeterminate  HIV indeterminate  HIV negative  
 Analyte results: HIV-1 Ab:  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test  
 HIV-2 Ab:  Positive  Negative  Indeterminate <sup>1</sup>Always complete the overall interpretation. Complete the analyte results when available.

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  Ag positive  Ab positive  Both (Ag and Ab positive)  Negative  Invalid  
 Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid 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<sup>2</sup> Overall interpretation:  Reactive  Nonreactive  Index value \_\_\_\_\_  
 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 \_\_\_\_\_  
 Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test <sup>2</sup>Complete the overall interpretation and the analyte results.

**HIV Detection Tests (Qualitative)**

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**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)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 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)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result  Detectable  Undetectable Copies/mL \_\_\_\_\_ Log \_\_\_\_\_ Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 at or closest to diagnosis: CD4 count \_\_\_\_\_ cells/ $\mu$ L CD4 percentage \_\_\_\_\_ % Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

First CD4 result <200 cells/ $\mu$ L or <14%: CD4 count \_\_\_\_\_ cells/ $\mu$ L CD4 percentage \_\_\_\_\_ % Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

Other CD4 result: CD4 count \_\_\_\_\_ cells/ $\mu$ L 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 for this algorithm \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.

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: \_\_\_\_\_

**Treatment/Services Referrals (record all dates as mm/dd/yyyy)**

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		This patient's partners will be notified about their HIV exposure and counseled by <input type="checkbox"/> 1-Health dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown	
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) <input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 2-Yes, client self-report, only Date of medical visit or prescription ___/___/_____			
<b>For Female Patient</b>			
This patient is receiving or has been referred for gynecological or obstetrical services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has this patient delivered live-born infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>For Children of Patient</b> (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 <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
*Street Address		*ZIP Code	
City	County	State/Country	

**Antiretroviral Use History (record all dates as mm/dd/yyyy)**

Main source of antiretroviral (ARV) use information (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			Date patient reported information ___/___/_____
Ever taken any ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, reason for ARV use (select all that apply)			
<input type="checkbox"/> HIV Tx	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PrEP	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PEP	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PMTCT	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> HBV Tx	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> Other (specify reason) _____	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) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			Date patient reported information ___/___/_____
Ever had previous positive HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date of first positive HIV test ___/___/_____	
Ever had a negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date 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 the 24 months before the first positive test ___ <input type="checkbox"/> Unknown			

**Comments**


**\*Local/Optional Fields**


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 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).