# 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 **□** 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** |

**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** □ 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 |

# 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** ( ) |

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

|  |  |
| --- | --- |
| **Sex Assigned at Birth****□** Male **□** Female **□** Unknown | **Country of Birth****□** US **□** Other/US dependency (please specify)  |
| **Date of Birth**  / /  | **Alias Date of Birth**  / /  |
| **Vital Status □** 1-Alive **□** 2-Dead | **Date of Death** / /  | **State of Death** |
| **Current Gender Identity** | **□** Male **□** Female **□** Transgender male-to-female (MTF) **□** Transgender female-to-male (FTM) **□** Unknown**□** Additional gender identity (specify)  |
| **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** |

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

|  |
| --- |
| **Address Type**(check all that apply to address below) **□** Residence at HIV diagnosis **□** Residence at stage 3 (AIDS) diagnosis **□** Check if SAME as current address |
| **\*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)

|  |  |
| --- | --- |
| **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** |

# 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 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 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) |  □ 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) |  □ Yes □ No □ Unknown |

# 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 data in Laboratory Data section, and enter patient or provider report of previous negative HIV test 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, please 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: |

# 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**1 ***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 | 1Always 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**2 ***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**  | 2Complete 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/µL **CD4 percentage**  % **Collection Date**  / /  |
| **Test brand name/Manufacturer** **Lab name**  |
| **Facility name** **Provider name**  |
| **First CD4 result <200 cells/µL or <14%: CD4 count**  cells/µL **CD4 percentage**  % **Collection Date**  / /  |
| **Test brand name/Manufacturer** **Lab name**  |
| **Facility name** **Provider name**  |
| **Other CD4 result: 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 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**: |

# 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** |

# 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 / /  |

# 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?** □ Yes □ No □ Unknown | **Date of first positive HIV test**  / /  |
| **Ever had a negative HIV test?** □ Yes □ No □ 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**  □ 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). |