Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at diagnosis)

Prior Dx	Surveillance Method	Report Source	STATE #	HARMS #	WEEK	YEAR	LexNex
YR: Site:	☐A ☐P ☐F ☐U					20___	

PATIENT IDENTIFIER INFORMATION

MR #_____ SSN #_____

Patient Name: _____ **Phone**: ( ) _____ - _____

(LAST, FIRST, MI)

Address:_____ **City**: _____ **County**: _____ **State**: ____ **Zip**: _____

PROVIDER INFORMATION

Provider Name: _____ **Phone**: ( ) _____ - _____

Facility: _____ **City**: _____ **State**: _____ **Zip**: _____

FORM INFORMATION

Date Completed: ___/___/_____ **Person reporting**: _____ **Phone**: ( ) _____ - _____

DEMOGRAPHIC INFORMATION

Diagnostic Status:	Date of Birth:	Current Status:	Date of Death:	State/Terr Death:
☐HIV Infection ☐AIDS	/ /	☐Alive ☐Dead ☐Unkn	/ /	

Sex at birth:	Current Gender Identity:	Ethnicity: (select one)	Race: (select one or more)	Country of Birth:
☐Male ☐Female	☐Male ☐Female ☐Trans Male-to-Female ☐Trans Female-to-Male ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown	☐Black or African Am ☐White ☐Asian ☐American Indian/Alaskan ☐Hawaiian/Other Pacific Islander ☐Unkn	☐US ☐Other _____ ☐Unknown

Residence at Diagnosis: Same as CURRENT address ☐

City:_____ **County**: FFLD HTFD LITCH NH NL MDX TLND WIND **State**: _____ **Zip**: _____

FACILITY OF DIAGNOSIS

Facility Name:

☐Inpatient ☐Outpatient ☐Other_____

City:

State/Country:

Identification Method: ☐Lab Report ☐Lab Audit ☐Viral Load ☐ICD-9 ☐Other:

Report Medium: Paper: ☐Field ☐Mail ☐Faxed ☐Phoned ☐Electronic transfer ☐Disc

RISK FACTOR HISTORY

Before the 1st positive HIV test, this patient had:

☐Sex with male ☐Sex with female Injected drugs: ☐Yes ☐No ☐Unknown

☐Other:

HETEROSEXUAL relations with the following:

☐IDU ☐Bisexual male ☐Person with documented HIV infection

☐Person w/ hemophilia ☐Transfusion/transplant recipient

Date of transfusion or transplant: / /

☐Worked in health-care or clinical lab setting

☐Congenital

☐**NO IDENTIFIED RISK (NIR)**

HIV TESTING HISTORY

Source: ☐Patient ☐Interview ☐Chart abstraction ☐Provider report ☐CW/XPEMS ☐Other

Date patient answered questions: _____/____/_____

Ever had a previous positive HIV test? ☐Yes ☐No ☐Unknown

Date of first positive HIV test: _____/____/_____

Has the patient ever had a *negative* HIV test? ☐Yes ☐No ☐Unknown

Date of the LAST negative HIV test: _____/____/_____

Number of HIV tests in the past 2 years: _____

ANTIRETROVIRAL USE HISTORY

Has the patient ever used antiretroviral medicines? ☐YES ☐NO ☐UNKN

ARV Use Type	ARV Medication	Date Began	Date last used
☐HIV Tx			
☐PrEP			
☐PEP			
☐PMTCT			
☐HBV Tx			
☐Other			

(HIV Tx – HIV treatment; PrEP - PRE-exposure prophylaxis; PEP - POST-exposure prophylaxis; PMTCT - prevention of mother-to-child transmission; HBV Tx – Hepatitis B treatment)

Laboratory Data

☐ Acute

HIV Antibody Tests (Non-type-differentiating)	RESULT	COLLECTION DATE
Test 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-2 IA ☐ Other _____	☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Rapid test? ☐ Yes ☐ No	/ /
HIV Antibody Tests (Type-differentiating)		
Test 2: ☐ Multispot ☐ Geenius ☐ Other _____	☐ HIV-1 ☐ HIV-2 ☐ Both HIV-1 and HIV-2 ☐ Neither (negative) ☐ Indeterminate	/ /
HIV Detection Tests (Quantitative)		
Test 3: ☐ HIV-1 RNA ☐ HIV-1 DNA NAAT ☐ Other _____	☐ Undetectable ☐ Det: _____ c/mL	/ /
HIV Detection Tests (Qualitative)		
Test 3: ☐ HIV-1 RNA/DNA NAAT ☐ HIV-1 Culture ☐ HIV-1 P24 Antigen ☐ HIV-2 RNA/DNA NAAT ☐ HIV-2 Culture	☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate	/ /

Why was the patient tested for HIV?

☐ Symptoms/dx w/ OI ☐ Routine test ☐ Pre-exposure medication (PrEP) screening ☐ Rule out HIV ☐ 'Just checking'
☐ Partner dx w/ HIV ☐ Regular tester ☐ Dx with STD ☐ Prenatal screening ☐ Establish Care ☐ Other:

Immunologic Testing:	
Closest to current diagnostic status:	COLLECTION DATE
CD4 count _____ cells/ul _____%	/ /
FIRST <200 or <14% of total lymphocytes:	
CD4 count _____ cells/ul _____%	/ /

HIV Genotype done?	COLLECTION DATE
☐ YES, Lab:_____ ☐ No	/ /

Physician Diagnosis:	
If HIV lab tests were not available, is HIV diagnosis documented by a physician?	☐ Yes ☐ No
If **YES**, provide date of documentation:	/ /

Clinical Status

Clinical Record Reviewed? ☐ Yes ☐ No AIDS INDICATOR DISEASES:	**Initial Dx Date** (mo/day/yr)	Presumptive	Definitive
Candidiasis, esophageal	/ /	☐	☐
Kaposi's sarcoma	/ /	☐	☐
M. tuberculosis	/ /	☐	☐
Pneumocystis jiroveci pneumonia	/ /	☐	☐
Pneumonia, recurrent	/ /	☐	☐
Toxoplasmosis of brain	/ /	☐	☐
Wasting syndrome due to HIV	/ /	☐	☐
Other:	/ /	☐	☐

Referrals

Has the patient been informed of their HIV results?	☐ Yes ☐ No ☐ Unkn
This patient's partners will be notified about their HIV exposure and counseled by: ☐ Physician/provider ☐ Patient ☐ Unknown ☐ Not applicable	This patient's medical treatment is primarily reimbursed by: ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ No coverage ☐ Other public funding ☐ Clinical trial/program ☐ Unknown

Where was the patient referred for HIV Care?

Provider Name:_____

Facility: _____

Health care providers can request assistance for notification of potentially exposed partners.

Would you like this assistance from DPH? ☐ Yes ☐ No

For Female Patients

Is patient receiving or been referred for OB/GYN services?	☐ Yes ☐ No ☐ Unkn
Is this patient currently pregnant?	☐ Yes ☐ No ☐ Unkn
If 'YES', when is the due date?	/ /
Where is the patient scheduled to deliver?	Hospital:

Comments: _____

_____

_____ 4.16