Adult HIV/AIDS Confidential Case Report
(for patients ≥ 13 years of age at time of diagnosis)
Return completed form to state/local health department
_____ Date received at Health Department (mm/dd/yyyy format)

I. Patient Name (last name, first name, and middle initial) and Address

Patient's Name	Alias	Phone No.

Address	City	County	State	ZIP Code

_____ Date form completed | Document source _____ or source code: **A** ___ ___ . ___ ___ . ___ ___

II. Health Department Use Only

Soundex Code	Did this report initiate a new case investigation? ☐ Yes ☐ No	Reporting Health Department	State Patient Number

Surveillance Method					City/County	Social Security Number (no dashes)
A	F	P	R	U		

Report Medium	Field Visit	Mailed	Faxed	Phone	E. Transfer	Diskette

Note: Record additional identifiers, such as Social Security number, in the Comments box (Section IX). Record the number and type of ID.

III. Demographic Information

Diagnostic Status at Report	Age at Diagnosis	Date of Birth	Alias Date of Birth	Sex at Birth	Country of Birth
☐ HIV infection (not AIDS) ☐ AIDS	Years (HIV) Years (AIDS)	Month / Day / Year	Month / Day / Year	☐ Male ☐ Female ☐ Unknown	☐ U.S. ☐ Other Specify, if **Other**:

Marital Status	Education	Current Sex	Gender	Vital Status	Date of Death	State/Territory of Death
☐ Married and separated ☐ Divorced ☐ Married ☐ Single and never married ☐ Widowed ☐ Unknown ☐ Other ☐ Not specified	☐ 8th grade or less ☐ Some high school ☐ High school graduate or GED ☐ Some college ☐ College degree ☐ Post-graduate work ☐ Some school, level unknown ☐ Unknown	☐ Male ☐ Female ☐ Intersexed	☐ Male ☐ Female ☐ Male to Female ☐ Female to Male ☐ Intersexed ☐ She Male ☐ Cross Dresser ☐ Drag Queen	☐ Alive ☐ Dead ☐ Unknown	Month / Day / Year	

Is this person a healthcare industry worker? _____ YES _____ NO

If **YES**, enter occupation:

Ethnicity	Extended Ethnicity	Race		Extended Race
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian ☐ White ☐ Unknown	

Residence at Diagnosis ☐Same address as patient address

Address	City	County	State/Country	ZIP Code

IV. Facility and Provider of Diagnosis / Facility of Care

☐ AIDS diagnosis ☐ Facility/Provider of care
☐ HIV diagnosis

Facility Name				
Address	City	County	State/Country	ZIP Code

Facility Setting	Specify setting, if **Federal**:	Facility Type	Specify type of facility:	HRSA Funding
☐ Public ☐ Federal ☐ State ☐ County ☐ City ☐ Private		☐ Inpatient Facility ☐ Outpatient Facility ☐ Emergency Room ☐ Screening, Diagnostic, Referral Agency ☐ Laboratory ☐ Other ☐ Unknown		☐ None ☐ Title IV ☐ Title I ☐ SPNS ☐ Title II ☐ Other ☐ Title III ☐ Unknown

Provider Name	Provider Specialty
Provider Phone No. / Medical Record No.	
Person Completing Form	Phone No.

V. Patient History

Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories):	YES	NO	UNK.
• Sex with male			
• Sex with female			
• Injected non-prescription drugs			
• Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received (mm/dd/yyyy) ___/___/_____			
• HETEROSEXUAL relations with any of the following: ○ Intravenous/injection drug user			
○ Bisexual male			
○ Person with hemophilia/coagulation disorder			
○ Transfusion recipient with documented HIV infection (consider documenting reason in the Comments section)			
○ Transplant recipient with documented HIV infection (consider documenting reason in the Comments section)			
○ Person with AIDS or documented HIV infection, risk not specified			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section) First date received Last date received			
• Received transplant of tissue/organs or artificial insemination			
• 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:			
• Other documented risk			
• No identified risk factor (NIR)			

VI. Laboratory Data

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

Collection Date: ____ / ____/_____ □ Rapid Test (check if rapid)

□ 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

Collection Date: ____ / ____/_____ □ Rapid Test (check if rapid)

□ 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** □ Reactive □ Nonreactive □ Not Reported **HIV-Ab** □ HIV-1 Reactive □ HIV-2 Reactive □ Both Reactive, Undifferentiated □ Both Nonreactive

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

Collection Date: ____ / ____/_____

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:

VII. Clinical Status

Clinical Record Reviewed □ Yes □ No

Enter date patient was diagnosed as: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy) mm/dd/yyyy

Symptomatic (not AIDS) mm/dd/yyyy

HIV Stage 3 (AIDS) Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy	HIV Stage 3 (AIDS) Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy
Candidiasis, bronchi, trachea, or lungs				Lymphoma, Burkitt's (or equivalent)			
Candidiasis, esophageal				Lymphoma, immunoblastic (or equivalent)			
Carcinoma, invasive cervical				Lymphoma, primary in brain			
Coccidioidomycosis, disseminated or extrapulmonary				Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary			
Cryptococcosis, extrapulmonary				M. tuberculosis, pulmonary			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				M. tuberculosis, disseminated or extrapulmonary			
Cytomegalovirus disease (other than in liver, spleen, or nodes)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
Cytomegalovirus retinitis (with loss of vision)				Pneumocystis carinii pneumonia			
HIV encephalopathy				Pneumonia, recurrent, in 12 mo. period			
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				Progressive multifocal leukoencephalopathy			
Histoplasmosis, disseminated or extrapulmonary				Salmonella septicemia, recurrent			
Isosporiasis, chronic intestinal (>1 mo. duration)				Toxoplasmosis of brain, onset at >1 mo. of age			
Kaposi's sarcoma				Wasting syndrome due to HIV			
Lymphoid interstitial pneumonia and/or pulmonary lymphoid				Def. = definitive diagnosis			Pres. = presumptive diagnosis

RVCT Case Number

If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition: □ Yes □ No □ Unknown

VIII. Treatment/Services Referrals

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: □ Health Department □ Physician/Provider □ Patient □ Unknown

This patient is receiving or has been referred for:
- HIV related medical services: □ Yes □ No □ Unknown
- Substance abuse treatment services: □ Yes □ No □ Not Applicable □ Unknown

This patient received or is receiving:
- Antiretroviral therapy: □ Yes □ No □ Unknown
- PCP prophylaxis: □ Yes □ No □ Unknown

This patient has been enrolled at (clinical trial): □ NIH Sponsored □ Other □ None □ Unknown

This patient has been enrolled at (clinic): □ HRSA Sponsored □ Other □ None □ Unknown

At time of HIV diagnosis, medical treatment primarily reimbursed by:

At time of AIDS diagnosis, medical treatment primarily reimbursed by:

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 the Comments section)

Child's Name | Child's Date of Birth

Child's First Soundex | Child's Last Soundex | Child's StateNo

Child's Coded ID

Hospital of Birth (if child was born at home, enter "home birth" for hospital name)			
Hospital Name			
Address			
City	County	State	Zip
Country			

IX. 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 ☐ 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			
	ARV medications:	Date began: __ __ /__ __/__ __ __ __	Date of last use: __ __ /__ __/

X. 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 24 months before first positive test # _____ ☐ Unknown

XI. Comments

XII. Local Fields

If individual reports a previous/concurrent STD diagnosis, select type	☐ CT ☐ GC ☐ Syphilis ☐ Unspecified	
If individual reports a previous/concurrent Hepatitis diagnosis, select type	☐ A ☐ B ☐ C ☐ Other ☐ Unspecified	
HIV Bubble Sheet ID Number =		
HIV Bubble Sheet Test Date (mm/yyyy)		
Is this individual enrolled in the AIDS Drug Assistance Program (ADAP)?	☐ Yes ☐ No ☐ Unknown	