

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				Address Date ____/____/____	
*Phone () _____		City		County		State/Country		*ZIP Code	
*Medical Record Number				*Other ID Type Social Security		* 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 CDCCenters 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		<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____		<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____	
						<i>Other Facility:</i> <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 Outpatient: Private Physician's Office Screening, Diagnostic, Referral Agency: Other Facility: Emergency Room
 Other, specify _____ Adult HIV Clinic CTS STD Clinic Laboratory Corrections Unknown
 Other, specify _____ Other, specify _____ 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 UnknownSex with female Yes No UnknownInjected non-prescription drugs Yes No Unknown

Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: _____
Date received (mm/dd/yyyy): ___/___/_____ Yes No Unknown

HETEROSEXUAL relations with any of the following:HETEROSEXUAL contact with intravenous/injection drug user Yes No UnknownHETEROSEXUAL contact with bisexual male Yes No UnknownHETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection Yes No UnknownHETEROSEXUAL contact with transfusion recipient with documented HIV infection Yes No UnknownHETEROSEXUAL contact with transplant recipient with documented HIV infection Yes No UnknownHETEROSEXUAL contact with person with documented HIV infection, risk not specified Yes No UnknownReceived 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 UnknownWorked 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

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
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
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/ μ L **CD4 percentage:** ___% **Collection Date:** ___/___/_____

First CD4 result <200 cells/ μ L or <14%: CD4 count: _____ cells/ μ L **CD4 percentage:** ___% **Collection Date:** ___/___/_____

Other CD4 result: CD4 count: _____ cells/ μ L **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†	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary†	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/identified 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	

†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? <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	
For Female Patient			
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
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 Soundex	Child'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	<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 _____
			*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): <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 _____	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 24 months before first positive test # _____ <input type="checkbox"/> Unknown			

Comments

Check OOS State: _____

***Local/Optional Fields**

PRISM # _____	NIR Status: _____
DOC # _____	NIR OP ____ NIR OP Date ____/____/____
Link with e-HARS stateno(s): _____	NIR CL ____ NIR CL Date ____/____/____
Other Risks: A ____ B/C ____ D ____ F ____ M ____ V ____ J ____	NIR RE ____ NIR RE Date ____/____/____
Hepatitis: A ____ B ____ C ____ Other ____ UNKnown ____	Initials (3) _____ Source Code A _____
If pregnant, list EDD (due date) ____/____/____	