



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)





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I. Patient Name (last name, first na	me, and middle init	tial) and Ad	ddress						
Patient's Name	Alias				Phone No.				
Address		City		County			Stat	е	ZIP Code
Date form complet	ted Document so	urce				0	r source	code: A_	· ·
			. Health Dep	artmont He	o Only				
Counday Code	Distable sesses in		. Health Dep						Ctata Dationt Number
Soundex Code	Did this report ini			керопіпд	Health Dep	artment			State Patient Number
	new case investig	gation?			SNHD				
	Yes		0:1 (0 1		•				
Surveillance Method	□ No		City/County	Clar	k			Social S	Security Number (no dashes)
	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 Info	rmation												
Diagnostic Status at Report	Age at Diagnosis		Date of Birth			Alias Date of Birth			;	Sex at Bir	Country of Birth		
HIV infection (not AIDS)	Years (HIV)	Month	h Day		Year	Month	Day	Year	Male		U.S.		
AIDS	Years								Fem			Other Specify, if Other :	
Marital Status	(AIDS) Education	Curre	ent Sex Gender Vital Status Date of D			ate of Dea	ath	State/Territory of Death					
Married and separated	8 th grade or less	Male	•	ı	Male	Alive			Month	Day	Year	Death	
Divorced	Some high school	Fem	Female Fer		emale	Dead							
Married	High school graduate	Inter	sexed	N	Male to	Unkn	own						
Single and never	or GED				emale			althcare in	dustry w	orker?	YES	SNO	
married	Some college				emale to				•				
Widowed	College degree				Male .								
Unknown	Post-graduate work				ntersexed	1/ VEO							
Other	Some school, level						enter occu	nter occupation:					
Not specified	unknown				Cross Oresser								
	Unknown				Orag Queen								
Ethnicity	Extended Ethnicity	у				Race	•				Exte	nded Race	
Hispanic/Latino			American Indian or Alaska Native Native Hawaiian										
Not Hispanic/Latino			Asian				White						
Unknown			Black o	r Afric	an American		Unkno	own					
Residence at Diagnos	sis Same ad	dress as	patient	addre	ess								
Address City				Count	/			State/Co	untry	ZIP Code			
IV. Facility and Provide	der of Diagnosis / Fac	ility of C	Care										
☐ AIDS diagnosis	☐ Facility/Provider of		Facility	Nam	e								
☐ HIV diagnosis													
Address			City			Count	/			State/Co	untry	ZIP Code	
			,								•		
Facility Setting	1		Facility	Туре)		1			Н	RSA Fur	ding	
□ Public	Specify setting, if Fed	deral:	□ Inpa	atient	Facility		Specify t	type of fac	ility: □ None			□ Title IV	
□ Federal			□ Out	patier	nt Facility						Title I	☐ SPNS	
□ State			□ Em	ergen	cy Room						Title II	□ Other	
□ County			☐ Screening, Diagnostic,							lπ	Title III	□ Unknown	
□ City			Ref	erral /	Agency	,							
□ Private			□ Lab										
· · · · · · · · · · · · · · · · · ·			□ Oth	er									
			□ Unk	nown	1								
Provider Name									P	Provider Specialty			
Provider Phone No.			Medica	al Rec	ord No.								
Person Completing Fo	rm									P	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 Date received (mm/dd/yyyyy)			
Specify clotting factor:			
HETEROSEXUAL relations with any of the following:			
o Intravenous/injection drug user			
o Bisexual male			
 Person with hemophilia/coagulation disorder 			
 Transfusion recipient with documented HIV infection (consider documenting reason in the Comments see 	,		
 Transplant recipient with documented HIV infection (consider documenting reason in the Comments section) 	tion)		
 Person with AIDS or documented HIV infection, risk not specified 			
 Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comr 	ments		
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 (ch	eck 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 (ch	eck 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: /	neck if rapid)
□ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)	
Test Brand Name/Manufacturer:	
RESULT: Ag reactive Both (Ag and Ab reactive) Neither (negative) Invalid/Indeterminate	
Collection Date: / Rapid Test (ch	eck if rapid)
□ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-2 Ab)	еск птаріц)
Test Brand Name/Manufacturer:	
RESULT*: HIV-1 Ag HIV-Ab	
□ Reactive □ Nonreactive □ Not Reported □ 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:	
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: /	<i></i>

Documentation of Tests Did documented laboratory test regular most engaged LIIV dispractic algorithm exiteric? — Vec. — No. — Unknown												
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	Enter date p was diagnos			natic acute retroviral s generalized lym			mm/dd	/уууу	Symptoma (not AIDS)	<u>tic</u>		mm/dd/yyyy
LUV Ctoro 2 (AIDC) Indicat	Diagona		Initial Dx	Initial Date)() ;	D:-		Initia	al Dx	Initial Date
HIV Stage 3 (AIDS) Indicat		1	Def. Pres	. mm/dd/yyyy		Stage 3 (AIE				Def.	Pres.	mm/dd/yyyy
Candidiasis, bronchi, trache	ea, or lungs					phoma, Burk	•	•	<u>′</u>			
Candidiasis, esophageal					+ -	phoma, imm			uivalent)			
Carcinoma, invasive cervic	al					phoma, prim	•					
Coccidioidomycosis, disser extrapulmonary	minated or				M. k	obacterium a ansasii, diss apulmonary						
Cryptococcosis, extrapulmo	onary				M. tu	ıberculosis,	pulmonar	у				
Cryptosporidiosis, chronic i duration)					extra	uberculosis, on pulmonary						
Cytomegalovirus disease (spleen, or nodes)	other than in li	ver,				obacterium, ies, dissemi						
Cytomegalovirus retinitis (v	vith loss of visi	on)				umocystis ca						
HIV encephalopathy					Pne	umonia, recu	urrent, in 1	12 mo. բ	period			
Herpes simplex: chronic ulce duration), bronchitis, pneumo	onitis, or esoph	agitis			Prog	ressive mult	tifocal leul	koence	ohalopathy			
Histoplasmosis, disseminat extrapulmonary					Salm	nonella septi	cemia, re	current				
Isosporiasis, chronic intesti duration)	inal (>1 mo.				Toxo age	pplasmosis o	of brain, or	nset at :	>1 mo. of			
Kaposi's sarcoma					Was	ting syndron	ne due to	HIV				
Lymphoid interstitial pneumonia and/or pulmonary lymphoid Def. = definitive diagnosis Pres. = presumptive diagnosis									ptive diagnosis			
RVCT Case Number			imm	V tests were not punodeficiency that inition:					_		Yes No Unknowr	1
		<u> </u>	uo								O I II I I I I I I I I I I I I I I I I	
VIII. Treatment/Services F	Referrals											
Has this patient been inforr infection?	med of his/her	HIV	□ Yes □ No □ Unkno	own		patient's par exposure an			fied about th	eir i		
	HIV related me services	edical	□ Yes □ No □ Unkno	own	T1:		5 d	Antiret	roviral therap	ру г	□ Yes □ No □ Unknov	vn
	Substance about reatment serv		□ Yes □ No □ Not A □ Unkno	pplicable own		patient receine ceiving:	ived or -	PCP p	rophylaxis	[□ Yes □ No □ Unknov	vn
	□ NIH Sponso □ Other	red	□ None □ Unkno	own		patient has l lled at (clinic		□ HRS	A Sponsore		□ None □ Unknov	vn
At time of HIV diagnosis, m	nedical treatme	ent				ne of AIDS o		medica	al treatment			
primarily reimbursed by: For Female Patient					prima	arily reimbur	sed by:					
This patient is receiving or has been referred for gynecological or obstetrical services:												
Is this patient currently preg	gnant?				□ Yes □ N			No	o 🗆 Unknown			
Has this patient delivered li	ive-born infants	s?				□ Yes			No		□ Unkn	own
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 I	_ast Soundex				Child's	StateNo			
Child's Coded ID												

Hospital of Birth (if child was born at home, e	ntor "homo hirth" for hospite	al nama)		
Hospital Name	nter nome bitti for nospite	ai name)		
Address				
City	County		State	Zip
Country	County		Cidio	
IX. HIV Antiretroviral Use History (record all	dates as mm/dd/yyyy)			
Main source of antiretroviral (ARV) use informat	tion (select one):		Date patient rep	orted information
☐ Patient Interview ☐ Medical Record Revi	,	□ NHM&E □ Other		
Ever taken any ARVs? Yes No Unkr				
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://		
□ PEP ARV medications:		Date began://		
			_	
□ PMTCT ARV medications:		Date began://		
☐ HBV Tx ARV medications:		Date began://	Date of last use:	'/
□ Other				
ARV medications:		Date began:II	Date of last use:	/
X. HIV Testing History (record all dates as n	nm/dd/yyyy)			
Main source of testing history information (sele	act one):		Date nation	nt reported information
Patient Interview Medical Record Review		NHM&E □ Other	-	_/
Ever had previous positive HIV test? Yes	□ No □ Unknown	Date of first positive	e HIV test//	
Ever had a negative HIV test? Yes No	□ Unknown	Date of last negative HIV test (If	date is from a	1 1
		lab test with test type, enter in Lab	Data section)	
Number of negative HIV tests within 24 months	s before first positive test #	□ Unknown		
XI. Comments				
Zii Commonto				
XII. Local Fields				
I previous/concurrent STD diagnosis.	CT □ GC □ Syphilis			
select type	Unspecified			
If individual reports a				
previous/concurrent Hepatitis diagnosis,		r		
select type	Unspecified			
HIV Bubble Sheet ID Number =				
Babble Greek In Hamber –				
HIV Bubble Sheet Test Date (mm/yyyy)				
Is this individual enrolled in the AIDS	Yes □ No			
D 4 1 1 D (4D4D)0	Unknown			