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 (enter all dates in 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	Does this report initiate a new case investigation or an update on a case?	Reporting Health Department SNHD	State Patient Number
	☑ New ☐ Update	State NV	
Surveillance Method		City/County Clark	City/County Patient Number
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)	Years (HIV)	Month Day Year	Month Day Year	☐ Male ☐ Female ☐ Unknown	☐ U.S. ☐ Other Specify, if **Other**:
☐ AIDS	Years (AIDS)				

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 I ☐ Title II ☐ Title III ☐ Title IV ☐ SPNS ☐ Other ☐ 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 Antibody Tests at Diagnosis (indicate first test—mm/dd/yyyy date)			Record additional HIV antibody tests			Collection Date (mm/dd/yyyy)
HIV-1 IFA	☐ Positive	☐ Negative	HIV-1 IFA	☐ Positive	☐ Negative	
HIV-1 Western Blot	☐ Positive	☐ Negative	HIV-1 Western Blot	☐ Positive	☐ Negative	
Rapid	☐ Positive	☐ Negative	Rapid	☐ Positive	☐ Negative	
HIV-1 EIA	☐ Positive	☐ Negative	HIV-1 EIA	☐ Positive	☐ Negative	
HIV-1/2 EIA	☐ Positive	☐ Negative	HIV-1/2 EIA	☐ Positive	☐ Negative	
HIV-2 EIA	☐ Positive	☐ Negative	HIV-2 EIA	☐ Positive	☐ Negative	
HIV-2 Western Blot	☐ Positive	☐ Negative	HIV-2 Western Blot	☐ Positive	☐ Negative	

HIV Detection Tests (record all tests—mm/dd/yyyy date)					
HIV-1 P24 Antigen	☐ Pos	☐ Neg	HIV-1 P24 Antigen	☐ Pos	☐ Neg
HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg	HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg
HIV-1 Culture	☐ Pos	☐ Neg	HIV-1 Culture	☐ Pos	☐ Neg
HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg	HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg
HIV-2 Culture	☐ Pos	☐ Neg	HIV-2 Culture	☐ Pos	☐ Neg

Immunologic Lab Tests (record additional CD4 tests in Comments section)			Collection Date (mm/dd/yyyy)
At or closest to current diagnostic status	CD4 count	cells/µL	
	CD4 percent	%	
First <200µL or <14%	CD4 count	cells/µL	
	CD4 percent	%	

Viral Load Tests (record most recent test; record additional viral load tests in Comments section)

	Copies/µL	Log	Collection Date (mm/dd/yyyy)
HIV-1 RNA NASBA			
HIV-1 RNA RT-PCR			
HIV-1 RNA bDNA			
HIV-1 RNA Other			

Date of last documented negative HIV test		Specify type of test:
Is HIV diagnosis documented by a physician?	☐ Yes ☐ No ☐ Unknown	If **YES**, enter date of diagnosis (mm/dd/yyyy):

VII. Clinical Status

Clinical Record Reviewed	Enter date patient was diagnosed as:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy) mm/dd/yyyy	Symptomatic (not AIDS) mm/dd/yyyy
□ Yes □ No			

AIDS Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy	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	This patient received or is receiving:	Antiretroviral therapy	□ Yes □ No □ Unknown
	Substance abuse treatment services	□ Yes □ No □ Not Applicable □ 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. Comments

X. Local Fields

If individual reports a previous/concurrent STD diagnosis, check all that apply □ CT □ GC □ Syphilis □Unspecified	
If individual reports a previous/concurrent Hepatitis diagnosis, check all that apply □ 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	