U.S. Department of Health and Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis)

*Information NOT transmitted to CDC

Centers for Disease Control

and Prevention (CDC)

I. Patient Identification (record all	dates as mm/dd/yyyy)		Form approved OM	B no. 0920-0573 Exp. 02/28/20		
*First Name *Mic	idle Name	*Last Name Sou		Last Name Soundex		
Alternate Name Type (ex: Alias, Married)	*First Name	*First Name *Middle Name		*Last Name		
Address Type Residential Correctional facility Bad address Foster home	Homeless Military	Other Postal	Shelter Temporary	,		
*Current Address, Street				Address Date / /		
*Phone City	County	Sta	ate/Country	*ZIP Code		
*Medical Record Number	*Other ID Type		*Number			
II. Health Department Use Only	(record all dates as mm/do	I/yyyy)				
Date Received at Health Department	eHARS Document	UID	State Numl	ber		
Reporting Health Dept – City/County		City/County	Number			
Document Source	Surveillance Metho Active		ollow up Re	abstraction Unknown		
Did this report initiate a new case investiga	tion? Report Medium					
Yes No Unknown	1-Field visit 2-Mailed	3-Faxed 4-Phone		Electronic transfer CD/disk		
III. Facility Providing Informatio	n (record all dates as mm	/dd/yyyy)				
Facility Name				*Phone		
*Street Address		Ci	ty			
County	State/Country			*ZIP Code		
Facility Type Outpat	tient: vate physician's office	Screening, Diagno Referral Agency:	stic,	Other Facility: Emergency room		
	ult HIV clinic	CTS		Laboratory		
Other, specify Oth	er, specify	STD clinic Other, specify		Corrections Unknown Other, specify		
Date Form Completed *Person	n Completing Form			*Phone		
IV. Patient Demographics (record	all dates as mm/dd/yyyy)					
Sex Assigned at Birth Male Fe	male Unknown		Date (D' ''	Alice Date of Birth		
US Other/US dependency (specify)			Date of Birth	Alias Date of Birth		
Vital Status Date of 1-Alive 2-Dead /	Death /	State of Death				

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.

Gender Identity Man Woman Additional gender identity (specify)	
Woman Additional gender identity (specify)	Date Identified
* * * * * * * * * * * * * * * * * * * *	
Total Control of the	
Transgender man Declined to answer Transgender woman Unknown	
	Date Identified
Sexual Orientation Straight or heterosexual Declined to answer	
Straight or heterosexual Declined to answer Lesbian or gay Unknown	/
Bisexual	
Additional sexual orientation (specify)	
Ethnicity Hispanic/Latino Not Hispanic/Latino Unknown	
Race American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Expanded Race	
(check all that apply) Asian White	
Black/African American Unknown	
W.B. III. as a Dispusation of the second of	
V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)	
Address Event Type (check all that apply to address below) Residence at HIV diagnosis Residence at stage 3 (AIDS) diagnosis Check if <u>SAME</u> as curr	rent address
Address Type *Street Address Residential Military	
Dad address Other	
City County Correctional facility Postal	
Foster home Shelter	
Homeless Temporary State/Country *	ZIP Code
VI. Facility of Diagnosis (add additional facilities in Comments)	
VI. Facility of Diagnosis (add additional facilities in Comments) Diagnosis Type (check all that apply to facility below) HIV Stage 3 (AIDS) Check if SAME as facility provided in the comments.	viding information
Diagnosis Type (check all that apply to facility below) HIV Stage 3 (AIDS) Check if <u>SAME</u> as facility prov	viding information *Phone
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Diagnosis Type (check all that apply to facility below) HIV Stage 3 (AIDS) Check if SAME as facility provided	*ZIP Code *ZIP Code lity: ncy room tory ions vn specify sk (enter in Comments o Unknown o Unknown

This report to 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, 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).

Date received

Specify clotting factor:

Yes

No

Unknown

		is of HIV infection, this	patient nau.			
HETEROSEXUAL relat	ions with any of the follo	owing:				
HETEROSEXUAL conta	HETEROSEXUAL contact with person who injected drugs				No	Unknown
HETEROSEXUAL contact with bisexual male				Yes	No	Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection				Yes	No	Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection				Yes	No	Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection				Yes	No	Unknown
HETEROSEXUAL conta	act with person with doc	umented HIV infection,	risk not specified	Yes	No	Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)				Yes	No	Unknown
First date received						
First date received/ Last date received/ Received transplant of tissue/organs or artificial insemination				Yes	No	Unknown
Worked in a healthcare or clinical laboratory setting			Yes	No	Unknown	
	re is being investigated of		y mode of exposure,			
specify occupation and		·	, ,			
Other documented risk	(include detail in Comm	ents)		Yes	No	Unknown
Acute HIV Infection			Illnesses (record all dates as mr			
Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section				Yes	No	Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)?			Yes	No	Unknown	
Date of sign/symptom						
Other evidence sugges	stive of acute HIV infection	on?		Yes	No	Unknown
If YES, describe:	1 1					
Date of evidence	<i></i>					
Opportunistic Illnesses						
Diagnosis		Dx Date	Diagnosis			Dx Date
		27.24.0	. 5			
Candidiasis, bronchi, tr	achea, or lungs		Lymphoma, Burkitt's (or equivale	nt)		
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Candidiasis, bronchi, tr	al	3.200	Lymphoma, Burkitt's (or equivale			
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Test Brand Name/M	_	o differentiating immu	unoassay (differentiates b Lab Name	petween HIV Ag and HIV Ab)
Facility Name			Provider Name	
Result Overall: Reactive Nonreactive	Reactive	-1/2 Ab: Reactive Nonreactive	Collection Date	Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample
TEST Test Brand Name/M		differentiating immur	noassay (differentiates an Lab Name	nong HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Facility Name			Provider Name	
Result ³ Overall interpretation Reactive Nonreactive Index Value	Analyte results: n: HIV-1 Ag: Reactive Nonreactive Not reportable due to high Ab level Index Value	HIV-1 Ab: Reactive Nonreactive Reactive undifferentiated	HIV-2 Ab: Reactive Nonreactive Reactive undifferentiated Index Value	Collection Date
TEST Test Brand Name/Ma		ting immunoassay (s	supplemental) (differentia Lab Name	ates between HIV-1 Ab and HIV-2 Ab)
Facility Name			Provider Name	
Result ⁴ Overall interpretatio HIV positive, unty HIV-1 positive wit HIV-2 cross-react HIV-2 positive wit HIV-1 cross-react HIV negative	pable HIV indeterminate h HIV-1 indeterminat iivity HIV-2 indeterminat h HIV-1 positive	e Negat	HIV-2 Ab: ve Positive	Collection Date
Test Brand Name/M	TEST anufacturer	HIV-1 WB	HIV-1 IFA HIV-2 Lab Name	
Facility Name			Provider Name	
Result Positive Negative Indeterminate		Colle	ction Date	Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample
HIV Detection Tests TEST HIV-1/2 RNA NAAT (Qualitative)				
Test Brand Name/M	anuiacturer		Lab Name	
Facility Name			Provider Name	
Result HIV-1 HIV-2 Both (HIV-1 and H	HIV, not differentia (HIV-1 or HIV-2) Neither (negative)	,	ction Date	Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample
Test Brand Name/M	TEST anufacturer	HIV-1 RNA NA	AT (Qualitative and Qua Lab Name	ntitative)
Facility Name			Provider Name	
Result Qualitative: Reactive Nonreactive	Analyte results: HIV-1 Quantitative Detectable above limit Detectable within limits Detectable below limit	Copies/mL Log		Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample

TEST HIV	-1 RNA/DNA NAAT (Q	ualitative) HIV-2	RNA/DNA NAAT (Qualitative)		
HIV	-1 culture	HIV-2	culture		
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Result			Testing Option (if applicable)		
Positive Collection	on Date//		Point-of-care test by provider		
Negative Indeterminate			Self-test, result directly observed by a provider ² Lab test, self-collected sample		
TEST HIV-1 RNA/	DNA NAAT (Quantitat	ive) HIV-2 RNA/D	NA NAAT (Quantitative)		
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Result	00/ml				
Detectable above minit	es/mL	_	Testing Option (if applicable)		
Detectable within limits Detectable below limit	Log	_	Point-of-care test by provider		
Not detected Collectio	n Date / /		Self-test, result directly observed by a provider ² Lab test, self-collected sample		
Drug Resistance Tests (Genotypic)		· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		
	TEST HIV-1 G	enotype (Unspecified)			
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Collection Date					
Immunologic Tests (CD4 count and percent	age)				
OD4 sount selle/ul OD4 never	••••	Callestian Data	1 1		
CD4 count cells/µL					
Facility Name		Provider Name			
Documentation of Tests					
Complete only if none of the following were positive	for HIV-1 : Western blot	t, IFA, culture, quantitativ	ve NAAT (RNA or DNA), qualitative NAAT (RNA or		
DNA), HIV-1/2 type-differentiating immunoassay (sup Did documented laboratory test results meet ap			icleotide sequence. Yes No Unknown		
	J	J	/ /		
If YES, provide specimen collection date of earlie	·				
Is earliest evidence of HIV infection diagnosis do If YES, provide date of diagnosis by physician	cumented by a physic	cian rather than by labo	oratory test results? Yes No Unknown		
Date of last documented negative HIV test result (before HIV diagnosis date)					
Specify type of test:					
Testing Option (if applicable)					
Point-of-care test by provider Self-tes	t, result directly observ	ved by a provider2	Lab test, self-collected sample		
² Results not directly observed by a provider should be recorded in HIV Testing History. ³ Complete the overall interpretation and the analyte results. ⁴ Always complete the overall interpretation. Complete the analyte results when available.					
X. Treatment/Services Referrals (record all dates as mm/dd/yyyy)					
Has this patient been informed of his/her HIV info	ection? This pati	ient's partners will be r	notified about their HIV exposure and counseled by		
Yes No Unknown	1-Hea	alth dept 2-Physic	ian/Provider 3-Patient 9-Unknown		
Evidence of receipt of HIV medical care other that (select one; record additional evidence in Comment		ult			
1-Yes, documented 2-Yes, client self-re	•	Date of medica	al visit or prescription/		
For Female Patient			· · ·		
This patient is receiving or has been referred	Is this patient curre	ently pregnant?	Has this patient delivered live-born infants?		
for gynecological or obstetrical services	Yes		Yes		
Yes	No		No		
No Unknown	Unknown		Unknown		

For Children	of Patient (record most recer	nt birth in these boxes; record	additional or mul	tiple births in Co	omments)	
*Child's Name	9	Child's Date of Birth	Child's Last Na	ame Soundex	Child's St	tate Number
Facility Name	of Birth (if child was born at hor	me, enter "home birth")				*Phone
Facility Type Inpatient: Hospital	Other, specify	Outpatient: Other, specify	Er	r Facility: mergency room orrections	Unknow Other, sp	
*Street Addre	ess			City		
County		State/Country				*ZIP Code
XI. Antire	troviral Use History (rec	ord all dates as mm/dd/yyyy)				
Main source	of antiretroviral (ARV) use infor	mation (select one) Date p	patient reported in	nformation I	Ever taken aı	ny ARVs?
Patient inte Medical re	erview Provider repor cord review NHM&E	rt Other	//_		Yes	No Unknown
If yes, reason	for ARV use (select all that appl	(y)				
	ARV medications	•		Date began /	1	Date of last use
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				/	/	/
Other (spe	cify reason)					
	ARV medications			Date began	/	Date of last use
XII. HIV Te	esting History (record all d	ates as mm/dd/yyyy)				
Main source Patient inte	of testing history information (serview Medical record review	•	NHM&E (Other	Date patient	reported information
Ever had prev	vious positive HIV test result? No Unknown	Date of first positive HIV tes	st result			positive test result from erformed by the patient? No Unknown
				1		
Ever had a ne	egative HIV test result? No Unknown	Date of last negative HIV tes (if date is from a lab test with t type, enter in Lab Data section	est			negative test result from erformed by the patient? No Unknown
		typo, onto in Las Bata occitor	<i>,</i>			
	egative HIV test results within the three regative test results we	-		t	Unknown Unknown	
XIII. Comr			, and panelin			
Aiii. Goiiii	1101110					
XIV. *Loca	II/Optional Fields					