

ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Information

(Record All Dates as mm/dd/yyyy)

Shaded Fields are Required.

Name of Person Completing Form:	Person's Phone Number: ()	STATENO:	CITYNO:
Date Form Completed: ____/____/____	Reporting Health Department - City/County:		Document Source:
Report Status: <input type="checkbox"/> 1- New <input type="checkbox"/> 2- Update	Physician's Name:	Physician's Phone Number: ()	Hospital/Facility Name:
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Surveillance Method: <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow Up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown		Report Medium: <input type="checkbox"/> 1- Field Visit <input type="checkbox"/> 2- Mailed <input type="checkbox"/> 3- Phone <input type="checkbox"/> 4- Electronic Transfer <input type="checkbox"/> 5- CD/Disk

II. Patient Identification

Patient Last Name:	Middle Name:	First Name:
Alternate Name Type (e.g. Alias, Married, etc.):	Last Name:	Middle Name: First 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 Street Address: City: County:		
State/Country:	ZIP Code:	Phone Number: ()
Social Security Number:		Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:

III. Patient Demographics *(See Appendix 2.0 for Further Details) (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"/> U.S. <input type="checkbox"/> Other/U.S. 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:		Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS
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"/> Other Gender Identity (specify): _____		Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Cambodian <input type="checkbox"/> Other (specify): _____
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	Expanded Ethnicity:	
Expanded Race:		

IV. Residence at Diagnosis *(See Appendix 3.0 for Further Details - Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)*

Address Type (check all that apply): <input type="checkbox"/> Residence at HIV Diagnosis <input type="checkbox"/> Residence at AIDS Diagnosis <input type="checkbox"/> Check if SAME as Current Address				
Address of Residence at HIV Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:
Address of Residence at AIDS Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:

V. Facility at Diagnosis (See Appendix 4.0 for Further Details - Add Additional Facilities in Comments and Local/Optional Fields Section) **STATENO:** _____

Diagnosis Type (check all that apply to facility): <input type="checkbox"/> HIV Diagnosis <input type="checkbox"/> AIDS Diagnosis <input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name:	Phone Number: ()	Street Address:	City:
County:	State/Country:	ZIP Code:	Provider Name:
Facility Type:	<u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		
	<u>Outpatient:</u> <input type="checkbox"/> Private Physician <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other (specify): _____		
	<u>Screening, Diagnostic, Referral Agency:</u> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other (specify): _____		
	<u>Other Facility:</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		

VI. Patient History (See Appendix 5.0 for Further Details - Respond to All Questions) **Pediatric Risk** (Please Enter in Comments and Local/Optional Fields Section)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:		
Sex with a male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Sex with a female: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Injected non-prescription drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:	Has the patient:	
Contact with intravenous/injection drug user (IDU): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received clotting factor for hemophilia/coagulation disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with a bisexual male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received transfusion of blood/blood components (non-clotting): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with a person with AIDS or documented HIV infection, risk not specified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other documented risk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with transplant recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(if yes, specify): _____	
Contact with transfusion recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	

VII. Laboratory Data (Record All Dates as mm/dd/yyyy) (See Instructions for Details)

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]		
TEST 1: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
TEST 2: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
TEST 3: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]		
TEST: <input type="checkbox"/> HIV-1/2 Differentiating (e.g. Multispot)		
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative)		
Collection Date: ____/____/____		

VII. Laboratory Data (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____

HIV Detection Tests (Qualitative)		
TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate	Collection Date: ____/____/____	
TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate	Collection Date: ____/____/____	
HIV Detection Tests (Quantitative Viral Load) <i>Note: Include earliest test after diagnosis</i>		
TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable	Copies/mL: _____	Log: _____ Collection Date: ____/____/____
TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable	Copies/mL: _____	Log: _____ Collection Date: ____/____/____
Immunologic Tests (CD4 Count and Percentage)		
CD4 at or closest to current diagnosis status: 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 <200 cells/μL or <14%:	CD4 count: _____ cells/μL	CD4 percentage: _____ % Collection Date: ____/____/____
Documentation of Tests (Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA])		
Did documented laboratory test results meet approved HIV diagnostic algorithm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, provide date (specimen collection date if known) of earliest positive test for this algorithm: ____/____/____		
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, provide date of documentation by physician: ____/____/____		

VIII. Clinical (Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)

	✓	Date		✓	Date
Candidiasis, esophageal			Kaposi's sarcoma		
Cryptococcosis, extrapulmonary			Pneumocystis carinii pneumonia		
Cytomegalovirus disease (other than in liver, spleen or nodes)			Wasting syndrome due to HIV		
Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis			Other (specify): _____		

IX. 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	
Patient's Medical Treatment is Primarily Reimbursed by: <input type="checkbox"/> 1- Medicaid <input type="checkbox"/> 2- Private Insurance/HMO <input type="checkbox"/> 3- No Coverage <input type="checkbox"/> 4- Other Public Funding <input type="checkbox"/> 9- Unknown	
For Female Patient:	
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

IX. Treatment/Services Referrals (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____

For Children of Patient: (Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)			
Child's Name:	Child's Soundex:	Child's Date of Birth: ____/____/____	
Child's Coded ID:	Child's STATENO:		
Hospital of Birth: (If Child Was Born at Home, Enter "Home Birth" for Hospital Name)			
Hospital Name:			Phone Number: ()
Street Address:		City:	
County:	State/Country:	ZIP Code:	

X. HIV Testing and Antiretroviral Use History (TTH) (Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)

Main Source of Testing and Treatment History Information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review			Date Patient Reported Information: ____/____/____
<input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____			
Ever Had a Positive HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of First Positive HIV Test: ____/____/____	Ever Had a Negative HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of Last Negative HIV Test: (If date is from a lab test with test type, enter in Laboratory Data Section.) ____/____/____
Number of Negative HIV Tests Within 24 Months Before First Positive Test (#): _____ <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: ____/____/____	Date ARVs Last Taken (mm/dd/yyyy): ____/____/____		

XI. Duplicate Review (Office use)

Status (check one): <input type="checkbox"/> Same As <input type="checkbox"/> Different Than <input type="checkbox"/> Pending	State Name: _____	STATENO: _____
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XII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by: _____ Entered by: _____ Entry Date: _____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

HIV Surveillance
1801 Solar Dr. Suite 250
Oxnard, CA 93030

TO REPORT THROUGH FAX, PLEASE FAX (805) 652-3320

TO REPORT THROUGH PHONE, PLEASE CALL (805) 652-5780