



Surveillance Section

**Adult HIV/AIDS Case Report Form
(ACRF) Instructions**

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California Department of Public Health

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Table of Contents

I.	HEALTH DEPARTMENT USE ONLY.....	4
II.	PATIENT IDENTIFICATION.....	6
III.	PATIENT DEMOGRAPHICS.....	7
IV.	RESIDENCE AT DIAGNOSIS.....	8
V.	FACILITY AT DIAGNOSIS.....	9
VI.	PATIENT HISTORY.....	10
VII.	LABORATORY DATA.....	13
VIII.	CLINICAL.....	18
IX.	TREATMENT/SERVICES REFERRALS.....	18
X.	HIV TESTING AND ANTIRETROVIRAL USE HISTORY (TTH).....	20
XI.	DUPLICATE REVIEW.....	244
XII.	COMMENTS AND LOCAL/OPTIONAL FIELDS.....	244
	Appendix.....	25
1.0	HEALTH DEPARTMENT USE ONLY.....	25
2.0	PATIENT DEMOGRAPHICS.....	26
3.0	RESIDENCE AT DIAGNOSIS.....	27
4.0	FACILITY OF DIAGNOSIS.....	288
5.0	PATIENT HISTORY.....	28

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Purpose of ACRF:

The Adult HIV/AIDS Case Report Form (CDPH 8641A [12/12]) is designed to collect information that promotes public health understanding of HIV infection morbidity and mortality among California residents **greater than or equal to 13 years of age** at time of diagnosis. California Health and Safety (H&S) Code Sections 121022 and 120130 authorize HIV/AIDS reporting by health care providers, laboratories, local health officers (LHOs), and the Office of AIDS (OA), Center for Infectious Diseases, California Department of Public Health (CDPH). The ACRF is used by health care providers and local public health department HIV/AIDS surveillance staff for HIV/AIDS reporting.

The ACRF in the context of document-based surveillance:

Unlike case-based data management, document-based data management allows all documents to be stored and retained electronically in their original formats. Instead of completing one form for a given reported case, fill out the applicable part of the form for each data source contributing to that HIV/AIDS case.

Patients for whom the ACRF is indicated:

- Each person with newly diagnosed HIV, stage 0, 1, 2, 3 (AIDS), or unknown stage.
- Each person with HIV infection progressing from an earlier or unknown stage to stage 3 (AIDS) diagnosis.
- When an HIV-infected patient dies, use this form to report the new information.
- Each person with HIV infection, who has been reported but for which updated information is available, such as: new reported CD4 or viral load tests; additional risk factor information; or updated address information.

Definition of variable designators:

- **Required:** Variables that must be collected and that are shaded on the form.
- **Optional:** Variables that are optional to collect and that are not shaded on the form.

For a patient to be accepted by the Centers for Disease Control and Prevention (CDC) as a case the following items must be present: STATENO, Last Name Soundex, DOB (at minimum the year), Sex at Birth, Vital Status or Date of Death, Ethnicity/Race and Confirmatory Lab or Physician Diagnosis. It is always best to provide as much information as you can but critical for those seven elements. A case must always be submitted to our office whether the seven elements are present or not; more information can be gathered later.

Disposition of form:

Reporting health care providers: Submit this form to your local public health department HIV/AIDS surveillance staff. See OA's website "HIV/AIDS Case Reporting" for a list of state and local contacts, (<http://www.cdph.ca.gov/programs/aids>). Local HIV/AIDS surveillance staff: Submit the completed form to OA per your contract's Scope of Work, Exhibit A, Part D, Objective 2. Data obtained is entered into the CDC Enhanced HIV/AIDS Reporting System (eHARS) and then transferred by OA, (without identifiers), to the CDC by encrypted electronic transfer via a secure data network.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

I. HEALTH DEPARTMENT USE ONLY - See Appendix 1.0 for Further Details

I. Health Department Use Only (See Appendix 1.0 for Further Details) (Record All Dates as mm/dd/yyyy) Shaded Fields are Required. All Others are Optional.

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	

1.1 NAME OF PERSON COMPLETING FORM (Required)

- Enter person's first and last name.

1.2 PERSON'S PHONE NUMBER (Required if available)

- Enter current area code and telephone number.

1.3 STATE NUMBER – STATENO (Required)

- Enter the assigned state patient number here and at the top of pages 2 – 4.
- Each patient should have a unique state number throughout the course of HIV disease in each state/jurisdiction where reported.
- Assigned numbers **should not** be reused, even if the case is later deleted.
- This variable is used, along with the state of report, to uniquely identify cases reported to CDC and to merge the state datasets without duplication.

1.4 CITY NUMBER – CITYNO (Optional)

- Enter the assigned city/county patient number.
- Each patient may have a unique city/county number throughout the course of HIV disease assigned by the separately funded city in which reported.
- Assigned numbers **should not** be reused, even if the case is later deleted.

1.5 DATE FORM COMPLETED (Required)

- Enter date in *mm/dd/yyyy* format.

1.6 REPORTING HEALTH DEPARTMENT - CITY/COUNTY (Required)

- Enter name of city and county of the health department that receives the report from providers of surveillance data.

1.7 DOCUMENT SOURCE (Required)

- Enter the code for the document source that provided the information for this report (formerly report source).
- To clearly identify multiple data sources for a given HIV case (all stages), use a separate case report form for each source.
- If coding proves difficult, write in document source for later coding.
- Refer to Appendix 1.0 for code information.

1.8 REPORT STATUS (Required)

Adult HIV/AIDS Case Report Form (ACRF) Instructions

- Check the appropriate box for if this is a New or Updated case.

1.9 PHYSICIAN'S NAME (Optional)

- Enter the person's name.

1.10 PHYSICIAN'S PHONE NUMBER (Optional)

- Enter person's current area code and telephone number.

1.11 HOSPITAL/FACILITY NAME (Optional)

- Enter the associated hospital or facility.

1.12 DID THIS REPORT INITIATE A NEW CASE INVESTIGATION? (Optional)

- Enter whether this case report initiated a new investigation by the health department - yes, no, or unknown.

1.13 SURVEILLANCE METHOD (Optional)

- Enter the method the case report was ascertained- active, passive, follow up, re-abstraction, or unknown.
- For definitions of active, passive, follow up, re-abstraction refer to the CDC's *Technical Guidance for HIV/AIDS Surveillance Programs, Volume I: Access to Source Data, Case Finding, and Completeness of Reporting*, located on the "HIV/AIDS Case Reporting" page on OA's website, <http://www.cdph.ca.gov/programs/aids>.

1.14 REPORT MEDIUM (Optional)

- Enter the medium in which the case report was submitted. Choose one of the following options: field visit, mail, phone, electronic transfer, or CD/disk.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

II. PATIENT IDENTIFICATION

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:	

Patient identifier information is for state/local health department use only and is not transmitted to the CDC. Enter the data below for all persons being reported with HIV.

2.1 PATIENT NAME (Required)

- Enter patient's last name, middle name, and first name.

2.2 ALTERNATE NAME TYPE (Optional)

- If available, write in the alternate name type (such as alias, married) and patient's alternative last name, middle name, and first name.

2.3 ADDRESS TYPE (Required)

- Select one of the address types (residential, bad address, correctional facility, foster home, homeless, postal, shelter, or temporary) for the patient's current address.

2.4 CURRENT STREET ADDRESS (Required)

- Enter the patient's current street address, city, and county.

2.5 STATE/COUNTRY (Required)

- Enter patient's current state/country.

2.6 ZIP CODE COUNTY (Required)

- Enter patient's current zip code.

2.7 PHONE (Required if available)

- Enter patient's current home area code and telephone number.

2.8 SOCIAL SECURITY NUMBER (Required if available)

- Enter the patient's Social Security Number.

2.9 – 2.12 OTHER ID TYPE AND NUMBER (Optional)

- Enter any additional patient's ID type and the number of the other ID, such as: medical record number, accession number, Report of Verified Case of Tuberculosis (RVCT) case number, Counseling and Testing Number (UNIQUE ID from the Counseling Information Form (CIF) or the Healthcare HIV Testing Form (HTF)), etc.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

III. PATIENT DEMOGRAPHICS - See Appendix 2.0 for Further Details

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: _____
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: _____		Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS	

- 3.1 SEX ASSIGNED AT BIRTH (Required)
 - Select patient's sex assigned at birth.
 - Refer to Appendix 2.0 for further details.
- 3.2 COUNTRY OF BIRTH (Optional)
 - Select applicable response from boxes provided.
 - Refer to Appendix 2.0 for legal values when dependency or country is to be specified.
- 3.3 DATE OF BIRTH (Required)
 - Enter patient's month, day, and year of birth.
- 3.4 ALIAS DATE OF BIRTH (Optional)
 - If available, write in the alias date of birth.
- 3.5 VITAL STATUS (Required)
 - Select applicable response.
 - For further guidance on death ascertainment, see CDC's *Technical Guidance for HIV/AIDS Surveillance Programs, Volume I: Policies and Procedures, Death Ascertainment*, located on the "HIV/AIDS Case Reporting" page on OA's website, <http://www.cdph.ca.gov/programs/aids>
- 3.6 DATE OF DEATH (Required)
 - If patient is deceased, enter date of death.
 - For further guidance on death ascertainment, see CDC's *Technical Guidance for HIV/AIDS Surveillance Programs, Volume I: Policies and Procedures, Death Ascertainment* located on the "HIV/AIDS Case Reporting" page on OA's website, <http://www.cdph.ca.gov/programs/aids>
- 3.7 STATE OF DEATH (Optional if applicable)
 - If patient is deceased, enter the state/territory where death occurred.
- 3.8 STATUS (Required)
 - HIV or AIDS

Adult HIV/AIDS Case Report Form (ACRF) Instructions

3.9 CURRENT GENDER IDENTITY (Optional if applicable)

- Enter the current gender identity of the patient: male, female, transgender male-to-female, transgender female-to-male, unknown, or additional gender identity.
- If the person's stated gender identity differs from the selections provided, please check the additional gender identity box and specify in the blank.

3.10 ETHNICITY (Required)

- Select applicable response.
- If no ethnicity information is available, select "Unknown."
- Do not choose unknown unless your search was unsuccessful.

3.11 EXPANDED ETHNICITY (Optional, if applicable)

- Enter more specific ethnicity information such as for Hispanic/Latino add "Cuban".

3.11 RACE (Required)

- Select patient's race even if information was submitted for ethnicity.
- Select more than one race if applicable.
- If no race information is available, select "Unknown."

3.13 EXPANDED RACE (Optional)

- Enter more specific race information for greater detail as appropriate.

IV. RESIDENCE AT DIAGNOSIS - See Appendix 3.0 for Further Details

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 <i>(check all that apply)</i> : <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:

4.1 ADDRESS TYPE (Required)

- Select one of the address types (residence at HIV diagnosis, residence at AIDS diagnosis, check if same as current address) for the patient's residence at diagnosis being reported on the ACRF.
- If the patient's residence at HIV diagnosis and AIDS diagnosis is the same, you may check both.

4.2 STREET ADDRESS, CITY, COUNTY, STATE, ZIP CODE (Required as appropriate for HIV or AIDS)

- Enter residence information at diagnosis.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

V. FACILITY AT DIAGNOSIS - See Appendix 4.0 for Further Details

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

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): _____		

5.1 DIAGNOSIS TYPE (Required)

- Enter the diagnosis type that corresponds to the facility at diagnosis being reported.

5.2 FACILITY NAME (Required)

- Enter name of the facility where patient was first diagnosed with diagnosis type being reported.
- If HIV, stage 0, 1, 2, and unknown or stage 3 (AIDS) diagnoses occurred at different facilities, enter name of each on separate forms, specifying which diagnosis occurred at which facility.

5.3 PHONE (Optional)

- Enter facility's current area code and telephone number.

5.4 STREET ADDRESS and CITY (Required)

- Enter facility's street address and city.

5.5 COUNTY, STATE/COUNTRY, ZIP CODE (Required)

- Enter county, state/county, zip code where facility at diagnosis is located.

5.6 PROVIDER NAME (Optional)

- Enter provider's name where patient first received a diagnosis of HIV stage 1, 2, or stage 3 (AIDS).

5.7 FACILITY TYPE (Required)

- Select applicable response corresponding to the type of facility where patient received diagnosis of HIV.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

VI. PATIENT HISTORY - See Appendix 5.0 for Further Details

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: (if yes, specify): <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	_____
Contact with transfusion recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____

This data yields information about how patients may have acquired their infections.

- Respond to each risk factor, selecting “Yes” for all factors that apply; “No” for those that do not apply (i.e., only select “No” if medical record specifically states this is not a risk factor; and “Unknown” for those for which investigation failed to yield an answer). If an investigation for a particular item was not performed, then leave it blank.
- Mark if the risk factor was a pediatric risk on the top of this section and enter additional information in the Comments and Local/Optional Fields section of the ACRF.

After 1997 and before the earliest known diagnosis of HIV infection, this patient had:

6.1 SEX WITH MALE (Required)

- Some examples of information from the medical record which would strongly indicate sex with a male are:
 - For male patient:
 - Married to or divorced from a male.
 - Rectal gonorrhea.
 - For female patient:
 - Married to or divorced from a male.
 - Boyfriend referenced in the medical record.
 - Living with a male “partner.”
 - History of pregnancy.

6.2 SEX WITH FEMALE (Required)

- Some examples of information from the medical record which would strongly indicate sex with a female are:
 - For male patient:
 - Married to or divorced from a female.
 - Has a biological child.
 - For female patient:
 - Married to or divorced from a female.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

6.3 INJECTED NON-PRESCRIPTION DRUGS (Required)

- Some examples of non-prescription drugs are heroin and methamphetamines

HETEROSEXUAL relations with any of the following:

6.4 HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING: (Required)

This section, addressed in 6.4.1 – 6.4.6.

6.4.1 CONTACT WITH INTRAVENOUS/INJECTION DRUG USER (Required)

- Select applicable response.

6.4.2 CONTACT WITH A BISEXUAL MALE (Required)

- Select applicable response.

6.4.3 CONTACT WITH A PERSON WITH AIDS OR DOCUMENTED HIV INFECTION, RISK NOT SPECIFIED (Required)

- Select applicable response.

6.4.4 CONTACT WITH A TRANSPLANT RECIPIENT WITH DOCUMENTED HIV (Required)

- Select applicable response.
- Consider documenting the reason for transplant in the Comments section.

6.4.5 CONTACT WITH TRANSFUSION RECIPIENT WITH DOCUMENTED HIV (Required)

- Select applicable response.
- Consider documenting the reason for transfusion in the Comments and Local/Optional Fields section of the ACRF.

Has the patient:

6.4.6 RECEIVED CLOTTING FACTOR FOR HEMOPHILIA/COAGULATION DISORDER (Required)

- “Coagulation disorder” or “hemophilia” refers only to a disorder of a clotting factor; factors are any of the circulating proteins named Factor I through Factor XII. These disorders include Hemophilia A and Von Willebrand’s disease (Factor VIII disorders) and Hemophilia B (a Factor IX disorder).
- Select applicable response.
- This risk factor is generally documented in the history and physical section of the patient’s medical chart.
 - If “Yes” specify the clotting factor and enter date received. Enter date in *mm/dd/yyyy* format.
 - If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select “No.”

6.4.7 RECEIVED TRANSFUSION OF BLOOD/BLOOD COMPONENTS (NON-CLOTTING) (Required)

Adult HIV/AIDS Case Report Form (ACRF) Instructions

- "Blood" is defined as a circulating tissue composed of a fluid portion (plasma) with suspended formed elements (red blood cells, white blood cells, platelets).
- "Blood components" that can be transfused include erythrocytes, leukocytes, platelets, and plasma.
- If "Yes," specify month, day, and year of first and last transfusions before occurrence of patient's HIV diagnosis.
- It is often helpful to document the reason for the transfusion in the Comments and Local/Optional Fields section of the ACRF.

6.4.8 OTHER DOCUMENTED RISK (SPECIFY)

- If the risk for the patient is not listed, please include it here.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

VII. LABORATORY DATA – Appropriate tests are required based on case status. See detailed instructions below

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

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: ____/____/____	
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: ____/____/____	
HIV Detection Tests (Quantitative Viral Load) <small>Note: Include earliest test after diagnosis</small>	
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/ 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 <200 cells/ μ L or <14%: CD4 count: _____ cells/ μ L 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: ____/____/____	

- “COLLECTION DATE” refers to the date when the specimen was collected or drawn.
- If search for either or both of these data was unsuccessful, then enter “.” for unknown day, month, or year of COLLECTION DATE, e.g., “06/./09.”
- Include all diagnostic and CD4 tests where possible. Where number of tests exceeds the number of fields available on the form, record in the Comments and Local/Optional Fields section of the ACRF.
- In the absence of laboratory tests, record HIV, stage 1, 2 or stage 3 (AIDS) diagnostic evidence documented in the chart by a physician.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

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 (<i>specify test</i>): _____	
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (<i>check if rapid</i>): <input type="checkbox"/> Collection Date: ____/____/____

7.1 HIV ANTIBODY TESTS (NON-TYPE DIFFERENTIATING) (Optional)

- Assuming active case finding, review patient’s chart and laboratory reports for the earliest date of documented HIV positivity, “Indeterminate” refers to indeterminate HIV antibody test results.
- Enter results and collection dates for first positive HIV antibody tests.
- The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate.
- Check the Rapid Test box if the test is rapid.

7.1.1 HIV-1 EIA, HIV-1/2 EIA, HIV-1/2 Ag/Ab, HIV-1 WB, HIV-1 IFA, HIV-2 EIA, HIV-2 WB, Other (specify test) (Optional)

- Enter result and collection date of each test.
- “Positive EIA” means repeatedly reactive tests on a single sample.
- If tests indicate HIV-1 or HIV-2 results separately, please specify the results as given in the laboratory report.
- Enter the name of the manufacturer of the test if known.

HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]	
TEST: <input type="checkbox"/> HIV-1/2 Differentiating (<i>e.g. Multispot</i>)	
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (<i>undifferentiated</i>) <input type="checkbox"/> Neither (<i>negative</i>)	Collection Date: ____/____/____

7.2 HIV ANTIBODY TESTS (TYPE DIFFERENTIATING) (Optional)

- Assuming active case finding, review patient’s chart and laboratory reports for the earliest date of documented HIV positivity.
- Enter results and collection dates for first positive HIV antibody tests. The possible results are: HIV-1, HIV-2, Both (undifferentiated), or Neither (negative).

Adult HIV/AIDS Case Report Form (ACRF) Instructions

HIV Detection Tests (Qualitative)	
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (<i>Qual</i>) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (<i>Qual</i>) <input type="checkbox"/> HIV-2 Culture
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____

7.3 HIV DETECTION TESTS (QUALITATIVE) (Optional)

- All varieties of these tests establish the presence of the pathogen HIV. By contrast, HIV tests such as the EIA or WB establish the presence of HIV antibodies—our immune system’s response to the pathogen.
- Select applicable response corresponding to earliest positive detection test.
- The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate.

7.3.1 HIV-1 RNA/DNA NAAT, HIV-1P24 ANTIGEN, HIV-1 CULTURE, HIV-2 RNA/DNA NAAT, HIV-2 CULTURE (Optional)

- Enter result and collection date of earliest test by culture.

HIV Detection Tests (Quantitative Viral Load) <small>Note: Include earliest test after diagnosis</small>	
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (<i>Quantitative Viral Load</i>) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (<i>specify test</i>): _____
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____

7.4 HIV DETECTION TESTS (QUANTITATIVE VIRAL LOAD) (Optional)

7.4.1 HIV-1 RNA/DNA NAAT, RT-PCR, bDNA, other specify test (Optional)

- The possible results are: Detectable or Undetectable.
- Enter results in units of copies per mL and log. Enter the month, day, and year test was collected. Viral load tests with undetectable results should also be entered here.
- COPIES/ML (Required). Where detectable results are reported with log data only, enter “greater than detection limits for this assay” under the Copies/mL field. Because undetectable results are typically reported as below the detection limits of the assay rather than by a specific quantitative value, enter “fewer than detectable by this assay” under the Copies/mL field.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Immunologic Tests (CD4 Count and Percentage)			
CD4 at or closest to current diagnosis status:	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 <200 cells/ μ L or <14%:	CD4 count: _____ cells/ μ L	CD4 percentage: _____ %	Collection Date: ____/____/____

7.5 IMMUNOLOGIC TESTS (CD4 COUNT AND PERCENTAGE) (Optional)

- Record both CD4 count and percentage when available. Enter specimen collection date to the reported CD4 test result.

7.5.1 CD4 AT OR CLOSEST TO CURRENT DIAGNOSIS STATUS

7.5.1.1 CD4 COUNT (Optional)

- For HIV reports, record the CD4 count closest to the time patient was determined to be HIV infected. If this information is not available when the initial case report is completed, it may be entered later. For HIV, stage 3 (AIDS) reports, record the CD4 count with date at or closest to the date of AIDS diagnosis. This AIDS diagnosis date is typically the date on which an AIDS defining illness is diagnosed or the specimen collection date of a CD4 count < 200 cells/ μ L.

7.5.1.2 CD4 PERCENTAGE (Optional)

- For HIV reports, record the CD4 percentage with date at or closest to the date of HIV diagnosis. For stage 3 (AIDS) reports, record the CD4 percentage at or closest to the time that an AIDS-defining clinical condition was first diagnosed. This AIDS diagnosis date is typically the date on which an AIDS-defining illness is diagnosed or the specimen collection date of a CD4 count < 200 cells/ μ L.

7.5.2 FIRST CD4 RESULT < 200 cells/ μ L or < 14%

7.5.2.1 CD4 COUNT (Optional)

- Enter results and specimen collection date of first CD4 < 200 cells/ μ L.

7.5.2.2 CD4 PERCENTAGE (Optional)

- Record results and specimen collection date of first CD4 <14%.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Documentation of Tests <i>(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])</i>
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: ____/____/____

7.6 DID DOCUMENTED LABORATORY TEST RESULTS MEET APPROVED HIV DIAGNOSTIC ALGORITHM? (Optional)

- With the most recently adopted HIV screening algorithms, eHARS will not consider two positive EIA tests as meeting case definition even though that test combination is valid to make a case. Checking “Yes” confirms that the right combination of tests is present to make a case. If “Yes” is not selected but all the proper tests are reported, eHARS will not see this patient as a confirmed case. It should only be used in the absence of a +WB, high viral load or other tests types that would meet the case definition and in the absence of a physician’s documentation of diagnosis.
- Select applicable response, enter “Yes”, “No” or “Unknown.”

7.6.1 IF “YES” TO 7.6, PROVIDE THE DATE OF THE SPECIMEN COLLECTION DATE IF KNOWN OF THE EARLIEST POSITIVE TEST FOR THIS ALGORITHM. (Optional)

7.7 IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY A PHYSICIAN? (Optional)

- Select applicable response. If laboratory evidence of an HIV test is unavailable in the patient’s medical or other record and written documentation of laboratory evidence of HIV infection consistent with the HIV case definition is noted by the physician, enter “Yes”; otherwise enter “No” or “Unknown.”

7.7.1 IF “YES” TO 7.7, PROVIDE DATE OF DOCUMENTATION BY PHYSICIAN (Optional)

- If antibody tests are not available in chart, enter date of the note in which the physician documents the patient’s HIV infection. Do not record earlier date stated by the patient or the date that the physician says in the note. For example, if a health care provider writes a note in a medical chart on 4/10/2010 stating the patient had positive HIV EIA and WB the previous month. You would record 4/10/2010 as the date of documentation by the physician.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

VIII. CLINICAL

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):		

8.1 CLINICAL

8.1.1 – 8.1.7 (Optional)

- Select all that apply and enter diagnosis dates.

8.1.8 OTHER (Optional)

This field is available for any other AIDS related opportunistic infections you may discover that are not listed above:

- Candidiasis, bronchi, trachea, or lungs
 - Carcinoma, invasive cervical
 - Coccidioidomycosis, disseminated or extrapulmonary
 - Cryptococcosis, extrapulmonary
 - Cryptosporidiosis, chronic intestinal (>1 month duration)
 - Cytomegalovirus, retinitis (with loss of vision)
 - HIV encephalopathy
 - Histoplasmosis, disseminated or extrapulmonary
 - Isosporiasis, chronic intestinal (>1 month duration)
 - Lymphoma, Burkitt's (or equivalent term)
 - Lymphoma, immunoblastic (or equivalent term)
 - Lymphoma, primary in brain
 - Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
 - M. tuberculosis, pulmonary*
 - M. tuberculosis, disseminated or extrapulmonary*
 - Mycobacterium, or other species or unidentified species, disseminated or extrapulmonary
 - Pneumonia, recurrent in 12-month period
 - Progressive multifocal leukoencephalopathy
 - Salmonella septicemia, recurrent
 - Toxoplasmosis of brain
 - Wasting syndrome, due to HIV
- *RVCT case number can be put in Section II, Patient Identification, as an ID number.

IX. TREATMENT/SERVICES REFERRALS

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

Adult HIV/AIDS Case Report Form (ACRF) Instructions

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

9.1 HAS THIS PATIENT BEEN INFORMED OF HIS/HER HIV INFECTION?

(Optional)

- Select applicable response.
- If notification is not documented, select "Unknown"

9.2 PATIENT'S MEDICAL TREATMENT IS PRIMARILY REIMBURSED BY (Optional)

- Select applicable response.

9.3 FOR FEMALE PATIENT

9.3.1 IS THIS PATIENT CURRENTLY PREGNANT? (Optional)

- Select applicable response. Response is dependent on which date was selected for populating the field "Date Form Completed." If patient was pregnant on that date, select "Yes."

9.3.2 HAS THIS PATIENT DELIVERED LIVE-BORN INFANTS? (Optional)

- Select applicable response.
- If "Yes", provide birth information for the most recent birth.

9.4 FOR CHILDREN OF PATIENT (RECORD MOST RECENT BIRTH BELOW; RECORD ADDITIONAL OR MULTIPLE BIRTHS IN COMMENTS AND LOCAL/OPTIONAL FIELDS SECTION) (Optional)

9.4.1 CHILD'S NAME (Optional)

- Enter name of child.

9.4.2 CHILD'S SOUNDEX (Optional)

- To be completed by state/local health department personnel.
- Retrieve soundex from the HIV registry (database) and enter here if child's name was previously entered in your database and a Stateno exists.
- If child's name has not been entered yet, enter name and date of birth information.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

9.4.3 CHILD'S DATE OF BIRTH (Optional)

- Enter child's month, day, and year of birth. Enter date in *mm/dd/yyyy* format.
- Child to whom field refers is from the most recent birth.

9.4.4 CHILD'S CODED ID (Optional)

- Enter any additional patient's ID type (such as Social Security Number) and the number of the other ID.

9.4.5 CHILD'S STATENO(Optional)

- To be completed by state/local health department personnel.
- This number is typically assigned by state/local health department personnel if the child is known to have received a diagnosis of HIV (all stages).

9.4.6 HOSPITAL OF BIRTH (Optional)

- Enter the name, street address, phone number, city, county, and state of the hospital where the child described at 9.4 above was born in the provided fields.
- If the child was born at home, enter "home birth."

X. HIV TESTING AND ANTIRETROVIRAL USE HISTORY (TTH)

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 <i>(select one)</i> : <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 <i>(specify)</i> : _____			____/____/____
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: <i>(If date is from a lab test with test type, enter in Laboratory Data Section.)</i> ____/____/____
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 <i>(mm/dd/yyyy)</i> : ____/____/____		

The Testing and Antiretroviral Use History (TTH) section is required for the use of state and local health departments that conduct HIV incidence surveillance (HIS). The medication-use questions are also required for areas conducting variant, atypical, and resistant HIV surveillance (VARHS). These TTH data are used along with the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) results to generate national, state, and local HIV incidence estimates. Unlike other sections on the ACRF, patient self-reported information is accepted for all answers.

10.1 MAIN SOURCE OF TESTING AND TREATMENT HISTORY INFORMATION (TTH) (Required)

- Check only one source, the main source from which the information in this section was obtained.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

- "Patient Interview" is selected only if the patient was directly asked a series of questions from this or another structured TTH form. Interviewer should be trained on the proper collection of TTH data.
- "Medical Record Review" indicates that this information was obtained through abstraction of medical charts, electronic medical records, or databases. Information may also come from a database of HIV test results or pharmacy records.
- "Provider Report" indicates this form is filled out by a health care provider.
- "NHM&E/PEMS" indicates that data were abstracted from the National HIV Monitoring and Evaluation (NHM&E) and the Program Evaluation and Monitoring System (PEMS) project forms or databases.
- "Other" indicates that information came from a source other than those listed above.

10.2 DATE PATIENT REPORTED INFORMATION (Required)

- The appropriate date to enter depends on the MAIN SOURCE OF TTH INFORMATION:
 - If there is a structured patient interview, enter the date of the interview.
 - For a medical record review, enter the date of the last patient encounter that contributed to the TTH information collected. If only a laboratory report was accessed, enter the date of receipt of the laboratory results. If there was no patient encounter or laboratory test receipt date, then enter the date the medical record review was performed.
 - If the ACRF is completed by a health care provider, enter the date of the last patient encounter when the most recent TTH information was obtained from the patient. If provider's information only came from another data source, such as a laboratory report, enter the date of receipt of the information. If there are no such dates, enter the date the ACRF was completed.
 - If there are no data available from the above sources, enter the date the ACRF was completed.

10.3 EVER HAD A POSITIVE HIV TEST? (Required)

- The purpose of this question is to report if any positive HIV test occurred before the known date of HIV diagnosis, for example a test performed in another state or country or an anonymous test. If there is a date of earlier positive HIV test, enter it in the next field on the form.
- Self-reported information is appropriate.
- Do not count indeterminate tests.
- "Yes" indicates evidence that the person had a previous positive HIV test, including patient self-report.
- "No" indicates sufficient evidence that there was no previous positive HIV test. Do not answer 'no' if there is a lack of evidence either way about previous tests.
- "Refused" indicates patient refused to answer the question or facility refused to permit medical record review.
- "Don't know" indicates that the patient, chart reviewer, or provider has no knowledge whether or not there was a previous positive HIV test, after searching for the information or asking the patient. The field should be left blank if the medical record was not searched or the question was not asked

Adult HIV/AIDS Case Report Form (ACRF) Instructions

10.4 DATE OF FIRST POSITIVE HIV TEST (Required)

- Record the date of the earliest known positive HIV test, including patient self-reported dates. It is acceptable to enter an estimated or incomplete date, as long as it contains a year.
- If it is known that there were no previous positive HIV tests, enter the date of the first positive HIV test (i.e., the collection date of the diagnostic HIV test) and answer "no" to the previous question ("Ever had previous positive HIV test").
- If you do not know the date of HIV diagnosis, enter the earliest known positive HIV test.

10.5 EVER HAD A NEGATIVE HIV TEST? (Required)

- Because this question is used to classify persons as new or previous testers for incidence estimation, it is important to not make assumptions. The mere absence of information about previous tests in a medical record should not be recorded as "no," since tests can occur in other venues.
- Self-reported information is accepted. Ignore indeterminate tests.
- "Yes" indicates there is knowledge of a previous negative HIV test, either self-reported or confirmed by a laboratory report. If the answer is "yes," enter the date in the next field on the form, if it is available.
- "No" indicates there is evidence that the person never had a negative HIV test. For example, the person states they never have been tested before. Do not enter "no" if there is simply no evidence either way about a previous HIV test.
- "Refused" indicates patient refused to answer the question or facility refused to permit medical record review.
- "Don't Know/Unknown" indicates there is insufficient evidence supporting or denying the occurrence of a negative HIV test, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

10.6 DATE OF LAST NEGATIVE HIV TEST (Required)

- This is the most important information for incidence estimation. This date is used to categorize persons as repeat testers and to estimate frequency of testing.
- Self-reported information is accepted. Documented negative HIV test dates also should be entered in the Laboratory Data section under date of last documented negative HIV test, along with the test type.
- Enter the date of the last known negative HIV test, either self-reported or confirmed by a laboratory test. The person may have had a more recent negative test at another facility, unknown to the provider or chart abstractor, but it is more important to enter any known date than to leave it blank.
- Incomplete dates are acceptable if the year is included.

10.7 NUMBER OF NEGATIVE HIV TESTS WITHIN 24 MONTHS BEFORE FIRST POSITIVE TEST (Required)

- Count the number of negative HIV tests in the 24 months before the first positive HIV test. Do not count indeterminate or positive HIV tests or those with unknown results.
- Enter "0" if it is known that the patient has never been tested for HIV before or never had a negative test.
- Check "Refused" if the patient refused to answer the question or facility refused to

Adult HIV/AIDS Case Report Form (ACRF) Instructions

permit medical record review.

- Check "Don't Know/Unknown" if the patient or person completing the form does not know or if the results of a test are unknown, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

10.8 EVER TAKEN ANY ANTIRETROVIRALS (ARVs)? (Required)

- This field indicates whether the patient has ever taken any ARV medication to prevent or treat HIV or hepatitis, particularly before HIV diagnosis. This is important because ARV use may affect STARHS results. Most patients have not taken ARVs before the date of HIV diagnosis, but some have taken them for hepatitis or for HIV pre-exposure prophylaxis.
- This question is also used to determine specimen eligibility for VARHS system that monitors the distribution of HIV-1 mutations associated with HIV drug resistance and subtypes among persons with newly diagnosed HIV infection.
- "Yes" indicates there is evidence that the person has taken ARVs, including self-reported. If "Yes", it is important to enter the dates when use began and, if appropriate, ended.
- "No" indicates there is evidence that the patient has never taken ARVs.
- "Refused" indicates that the patient refused to answer the question or facility refused to permit medical record review.
- "Don't Know/Unknown" should be used when the person completing the form does not know whether or not the patient has ever taken ARVs, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

10.9 IF YES, WHAT ARV MEDICATIONS? (Required)

- This field is used for verification that the medication taken was actually an antiretroviral medication.
- It is not necessary to list all medications, only one. However, more can be listed if there is space. Enter "unspecified" if an ARV was taken but the name is not known.

10.10 DATES ARVs FIRST TAKEN: (Required)

- Enter the earliest date that the patient ever took ARVs, even if ARV use was sporadic.
- If the first time ARVs were taken occurred after HIV diagnosis, it is very important to enter a date, even an estimated date, later than the date of HIV diagnosis.

10.11 DATES ARVs LAST TAKEN: (Required)

- Enter the last known date of ARV use.
- For patients currently on ARVs, record the date of the last prescription or known usage. If the information is collected during a patient interview, the date would be the interview date. If the information was collected as part of a medical record review, record the date of the last prescription or date of the last physician's note.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

XI. DUPLICATE REVIEW

XI. Duplicate Review

Status (check one): <input type="checkbox"/> Same As <input type="checkbox"/> Different Than <input type="checkbox"/> Pending	State Name:	STATENO:
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11.1 STATUS (Optional)

- This section can be used for information related to duplicate review.
- If a case is determined to be a duplicate, it should be determined if the duplicate is "Same As" or "Different Than" the other case.

11.2 STATE (Optional)

- If a duplicate is found, enter the state here.

11.3 STATENO (Required)

- If a duplicate case was found, the STATENO of the duplicate case must go here.

XII. COMMENTS AND LOCAL/OPTIONAL FIELDS

XII. Comments and Local/Optional Fields

12.1 COMMENTS AND LOCAL/OPTIONAL FIELDS (Optional)

- This section can be used for information not requested on the form or for information requested but where there might not be room in the space provided.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Appendix

1.0 HEALTH DEPARTMENT USE ONLY

1.1 DOCUMENT SOURCE

- If “Other database,” “Other Clinic,” “Other,” or “Out of state” is selected, specify source in Comments and Local/Optional Fields section.
- Two-level codes for document source are shown below. The first level of source code (A02, A06, A04) is required, and the second level (01, 17, 25) is recommended.

Document Source Codes for HIV Reporting

<i>HARS Document Source</i>	<i>eHARS Document Source</i>
01 = Private Physician	A02.01- OutPatient Record/Private Physician
02 = Death Document review	A06.07 - Other Database Death Certificate
04 = AZT registry database	A06.01 Other Database/AIDS Drug Assistance Program
05 = ASD database	A06.02 = Other DB/ASD database
06 = Medical records	A01 - Inpatient Records A02- Outpatient Records
07 = PSD database	A06.20 = Other DB/PSD database
08 = NDI database	A06.17 = Other DB/National Death Index (NDI) Search
09 = TB registry	A06.25 = Other DB/Tuberculosis registry
10 = SHAS database	A06.22 = Other DB/SHAS database
11 = Other database	A06- Other databases of information
13 = Discharge summary	A06.13 = Other DB/Hospital billing summary or Discharge db
14 = Billing Summary	A06.13 = Other DB/Hospital billing summary or Discharge db
15 = Case Management Agency	A04.04 = SDRA/HIV Case Management Agency
20 = HRSA funded clinic	A06.14 = Other DB/HRSA HIV CARE database
21 = Coroner	A07.02 = OFR/Coroner not associated with inpatient facility
22 = HIV Counseling and Testing	A04.05 = SDRA/HIV Counseling and Testing Site
23 = STD clinic	A04.11 = SDRA/STD Clinic
24 = Drug treatment	A02.19 = OP/Drug Treatment Center
25 = Family planning	A04.03 = SDRA/Family Planning Clinic
26 = Prenatal/obstetrics	A02.08 = OP/Prenatal Clinic or Records
27 = Pediatrics clinic	A02.11 = OP/Pediatric clinic
28 = Tuberculosis clinic	A02.12 = OP/TB clinic
29 = Other Clinic	A02.25 = OP/Other Clinic
30 = Correctional facility	A07.01 = OFR/Prison, jail or other correctional facility
31 = Hospital, inpatient	A01.01 = Inpatient Facility
32 = Hospital, outpatient	A02.01 = Outpatient Facility
33 = Emergency room	A03 = Emergency room record not resulting in admission
34 = Laboratory	A05.01 = Laboratory

Adult HIV/AIDS Case Report Form (ACRF) Instructions

35 = Blood bank	A04.01 = SDRA/Blood Bank
36 = Out of state report	A06.18 = Other DB/Out of State Report
38 = Pediatric HIV Clinic	A02.09 = OP/Pediatric HIV Clinic
39 = Adult HIV Clinic	A02.04 = OP/Adult HIV Clinic
41 = Hemophilia Treatment	A02.17 = OP/Hemophilia Treatment Center
42 = Medicaid Records	A06.16 = Other DB/Medicaid records
88 = Other Source	A 10 = Other Source

2.0 PATIENT DEMOGRAPHICS

2.1 Refers to the person’s assigned sex at birth. In addition to “male” or “female” sex at birth, CDC-supplied software (eHARS) includes a third choice of “Unknown.”

- The person completing the form may also record current gender identity.
- Selections and legal values for “CURRENT GENDER IDENTITY” from eHARS Lookup codes are as follows:

CURRENT_GENDER = M = Person currently identifies as male
CURRENT_GENDER = F = Person currently identifies as female
CURRENT_GENDER = MTF = Person currently identifies as transgender, male-to-female or as a similar gender identity (e.g., transwoman, transfeminine)
CURRENT_GENDER = FTM = Person currently identifies as transgender, female-to-male or as a similar gender identity (e.g., transman, transmasculine)
CURRENT_GENDER = AD = Person currently identifies as a gender that does not correspond with those listed above (e.g., gender queer) Please specify the current gender identity.
CURRENT_GENDER = U = Person’s current gender identity is unknown

2.2 COUNTRY OF BIRTH

- Select first from boxes provided:
U.S.
Other/U.S. dependency (please specify)
- For patients born in U.S. dependencies, specify from the following table:

U.S. Dependencies	
American Samoa	Pacific Trust Territories
Guam	Palau
Johnston Atoll	Puerto Rico
Mariana Islands	Ryukyu Islands
Marshall Islands	Swan Islands
Micronesia	U.S. Virgin Islands

Adult HIV/AIDS Case Report Form (ACRF) Instructions

Midway Islands	Wake Island
Navassa Island	

2.3 ETHNICITY

- Regardless of the presence of race or absence of any information, collect data on ethnicity.

2.4 RACE

- At a minimum, collect data on the following categories:
 - White;
 - Black or African American;
 - American Indian or Alaskan Native;
 - Asian; and
 - Pacific Islander.

3.0 RESIDENCE AT DIAGNOSIS

- Residence may be identical to that listed above in Patient ID, unless otherwise noted in the chart.
- For HIV, stage 1-2 case reports, enter residence at the time of the first positive confirmatory test for HIV infection.
- If a diagnostic test result is not available, enter patient's residence at the date of *physician diagnosis* of HIV infection.
- For HIV, stage 3 (AIDS) case report, enter patient's residence at the date of the first AIDS- defining clinical condition **or** the date of the first immunologic marker that reaches AIDS-defining thresholds.

Residence assignment can be problematic for patients who:

- Have multiple residences.
- Are on vacation.
- Reside at a school.
- Are foster children.
- Are members of the Armed Forces.
- Are institutionalized in correctional or other types of facilities.
- Are foreign to the United States.
- Are U.S. citizens diagnosed abroad.

RESIDENCE, INCARCERATED

- Enter home of record for sites of relatively brief incarceration such as county jails.
- For patients who are incarcerated in state or federal correctional facilities at the time of diagnosis, record the correctional facility's address.
- For patients incarcerated in city or county jails, record home address; enter jail address only after unsuccessful search for address of patient's home of record.

RESIDENCE, HOMELESS

- For homeless patients, enter the address that most accurately describes where they stay, including a shelter address if applicable.

Adult HIV/AIDS Case Report Form (ACRF) Instructions

- People without a usual residence should be reported by the jurisdiction where they were staying at the time of diagnosis.

4.0 FACILITY OF DIAGNOSIS

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- For HIV, stage 1 and stage 2 case reports, enter the name of the facility where the patient first had blood drawn and was given a diagnosis of HIV infection.
- If test results are not in the medical record, enter the name of the facility where the patient's HIV infection was diagnosed and documented by the health care provider.
- For HIV, stage 3 (AIDS) case report, enter the name of the facility where the patient's AIDS-defining clinical condition was first diagnosed, or a CD4 count below 200 cells/ μ L or a CD4 percentage below 14 was documented, whichever came first.
- Enter facility/physician name uniformly to prevent the occurrence of multiple names for a given facility.
- If a physician name is listed without a facility name, enter physician name.

5.0 PATIENT HISTORY

- Surveillance staff has found patient history information within charts at discharge summary, history and physical, social service notes, counseling and testing notes, and STD diagnosis notes.
- Where not explicitly annotated, contact patient's provider about risk factor information.
- This information can be difficult to find, particularly if the patient has not been interviewed.

5.1 HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING:

5.1.1 PERSON WITH HEMOPHILIA/COAGULATION DISORDER WITH DOCUMENTED HIV INFECTION

- Do not include other bleeding disorders, such as thrombocytopenia, treatable by platelet transfusion.
- If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select "No."
- Cases of public health importance (COPHI) is covered in the CDC *Technical Guide for HIV/AIDS Surveillance Programs, Volume I: Policies and Procedures, Risk Factor Ascertainment, Cases of Public Health Importance*, located on the "HIV/AIDS Case Reporting" page on OA's website, <http://www.cdph.ca.gov/programs/aids>.