

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

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

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

Patient's name (last, first, MI) _____ Telephone number () _____ Social Security Number _____

Address (number, street) _____ City _____ County _____ State _____ ZIP code _____

Date form completed: Month _____ Day _____ Year _____

Report status: 1 New 2 Update

Report source: _____ Reporting health department: _____ State patient number: _____ City/county patient number: _____

Soundex code: _____ Date of birth: Month _____ Day _____ Year _____

Gender: 1 M 3 M ▶ F 2 F 4 F ▶ M

CLIA number: _____ Lab report/Accession number: _____ *Confidential C&T number: _____

*Publicly funded confidential counseling and testing sites only

III. Demographic Information

Diagnosis status at report (check one): 1 HIV Infection (not AIDS)..... 2 AIDS.....

Age at Diagnosis Years: _____

Current status: 1 Alive 2 Dead 9 Unknown

Date of death: Month _____ Day _____ Year _____

State/Territory of death: _____

Country of birth: 1 U.S. 7 U.S. Territories (including Puerto Rico) 8 Other (specify): _____ 9 Unknown

ETHNICITY: 1 Hispanic 2 Not Hispanic nor Latino

RACE: American Indian/Alaskan Native Black or African American Asian Native Hawaiian/Other Pacific Islander White Unknown

Expanded race (specify): _____

Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country: _____

Residence at first diagnosis of HIV or AIDS: Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.)

City: _____ County: _____ State/Country: _____ ZIP code: _____

IV. Facility of Diagnosis (LHDs use approved abbreviations from "Facility List.")

Facility name: _____ City: _____ State/Country: _____

Facility setting (check one): 1 Public 2 Private 3 Federal 9 Unknown

Facility type (check one): 01 Physician, HMO 22 Counseling and Testing Site 29 Community Health Center 30 Correctional Facility 31 Hospital, inpatient 32 Hospital, outpatient 88 Other (specify): _____ 99 Unknown

V. Patient Risk History (Check all that apply.)

| | | | | | |
|---|----------------|---|---|---|-----------------------|
| • Sex with a male..... | Yes No Unknown | 1 0 9 | • Received clotting factor for hemophilia/coagulation disorder | Yes No Unknown | 1 0 9 |
| • Sex with a female..... | 1 0 9 | • Injected nonprescription drugs..... | 1 0 9 | Specify disorder: | |
| • HETEROSEXUAL relations with any of the following: | Yes No Unknown | 1 0 9 | <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) | | |
| • Intravenous/injection drug user..... | 1 0 9 | • Bisexual male..... | 1 0 9 | <input type="checkbox"/> 8 Other (specify): _____ | |
| • Person with hemophilia/coagulation disorder..... | 1 0 9 | • Transfusion recipient with documented HIV infection..... | 1 0 9 | • Received transfusion of blood/components (other than clotting factor) | Month Year Month Year |
| • Transplant recipient with documented HIV infection..... | 1 0 9 | • Person with AIDS or documented HIV infection, risk not specified..... | Yes No Unknown | 1 0 9 | First: Last: |
| | 1 0 9 | | • Received transplant of tissue/organs or artificial insemination. | Yes No Unknown | 1 0 9 |
| | | | • Worked in a health care or clinical laboratory setting..... | 1 0 9 | |
| | | | (Specify occupation): _____ | Yes No Unknown | 1 0 9 |
| | | | • Perinatally-acquired HIV infection regardless of year of birth... | 1 0 9 | |
| | | | • Other (specify) _____ | 1 0 9 | |

VI. Laboratory Data (Indicate first documented test(s).)

A. HIV Antibody Test at Initial HIV/AIDS Diagnosis

| | | |
|------------------------------------|----------------|-------|
| • HIV-1 EIA..... | Month Day Year | _____ |
| • HIV-1/HIV-2 combination EIA..... | _____ | |
| • Rapid HIV-1 EIA..... | _____ | |
| • HIV-1 Western Blot/IFA..... | _____ | |
| • Other HIV antibody test..... | _____ | |

(Specify): _____

B. Positive HIV Detection Test (Record earliest test.)

Culture Antigen DNA PCR RNA PCR

Other (specify): _____

Date of last documented **negative** HIV test..... Month Day Year _____

Specify type: _____

Specify facility type (use codes in Section IV): 01 22 29 30 31 32 99 88 (Specify): _____

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?..... Yes No Unknown

1 0 9

Month Day Year _____

If yes, provide date of documentation by physician..... _____

C. HIV Viral Load Test (Record earliest test.)

Test type*: _____ Version*: _____

Other (specify type and version): _____

Test result (Record in copies/mL and log₁₀ values.)

Detectable Copies/mL: _____, _____, _____

Log₁₀: _____

Greater than: _____, _____, _____ copies/mL

Undetectable Less than: _____ copies/mL

* Test type and version: 11 = NucliSens® HIV-1 QT (Organon-NASBA)
12 = Amplicor HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5
13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0
18 = Other (kit name/manufacturer/version)

D. Immunologic Lab Tests - At or closest to current diagnostic status

• CD4 count..... _____ cells/μl

• CD4 percent..... _____ %

First <200 μl or <14% _____

• CD4 count..... _____ cells/μl

• CD4 percent..... _____ %

VII. Provider Information

| | | | | | | | |
|------------------------------------|--|------|-------|----------------------------------|------------------------|--|--|
| Physician's name (last, first, MI) | | | | Physician's telephone number () | | Patient's/inmate's medical record number | |
| Address (number, street) | | City | State | ZIP code | Person completing form | Telephone number () | |

VIII. Clinical Status

Clinical record reviewed Yes No Enter date patient was diagnosed as: Month Day Year

• Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy).....

• Symptomatic (not AIDS).....

| AIDS INDICATOR DISEASES | Initial Diagnosis | | Initial Date | | AIDS INDICATOR DISEASES | Initial Diagnosis | | Initial Date | |
|--|-------------------|-------|--------------|------|---|-------------------|-------|--------------|------|
| | Def. | Pres. | Month | Year | | Def. | Pres. | Month | Year |
| Candidiasis, bronchi, trachea, or lungs | 1 | NA | | | Lymphoma, Burkitt's (or equivalent term) | 1 | NA | | |
| Candidiasis, esophageal | 1 | 2 | | | Lymphoma, immunoblastic (or equivalent term) | 1 | NA | | |
| Carcinoma, invasive cervical | 1 | NA | | | Lymphoma, primary in brain | 1 | NA | | |
| Coccidioidomycosis, disseminated or extrapulmonary | 1 | NA | | | <i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary | 1 | 2 | | |
| Cryptococcosis, extrapulmonary | 1 | NA | | | <i>M. tuberculosis</i> , pulmonary* | 1 | 2 | | |
| Cryptosporidiosis, chronic intestinal (>1 month duration) | 1 | NA | | | <i>M. tuberculosis</i> , disseminated or extrapulmonary* | 1 | 2 | | |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) | 1 | NA | | | <i>Mycobacterium</i> of other species or unidentified species, disseminated or extrapulmonary | 1 | 2 | | |
| Cytomegalovirus retinitis (with loss of vision) | 1 | 2 | | | <i>Pneumocystis jirovecii</i> pneumonia (PCP) | 1 | 2 | | |
| HIV encephalopathy | 1 | NA | | | Pneumonia, recurrent, in 12-month period | 1 | 2 | | |
| Herpes simplex: chronic ulcer(s) (>1 month duration): or bronchitis, pneumonitis, or esophagitis | 1 | NA | | | Progressive multifocal leukoencephalopathy | 1 | NA | | |
| Histoplasmosis, disseminated or extrapulmonary | 1 | NA | | | Salmonella septicemia, recurrent | 1 | NA | | |
| Isosporiasis, chronic intestinal (>1 month duration) | 1 | NA | | | Toxoplasmosis of brain | 1 | 2 | | |
| Kaposi's sarcoma | 1 | 2 | | | Wasting syndrome due to HIV | 1 | NA | | |

Def. = definitive diagnosis Pres. = presumptive diagnosis * RVCT case number:

If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes No Unknown

1 0 9

IX. Treatment/Services Referrals

| | |
|--|---|
| Has the patient been informed of his/her HIV infection?..... Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 This patient's partner(s) has been or will be notified about their HIV exposure and counseled by: <input type="checkbox"/> 1 Health Department <input type="checkbox"/> 2 Physician/Provider <input type="checkbox"/> 3 Patient <input type="checkbox"/> 9 Unknown This patient is receiving or has been referred for: • HIV-related medical services..... Yes No NA Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> - <input type="checkbox"/> 9 • Substance abuse treatment services..... <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 8 <input type="checkbox"/> 9 This patient received or is receiving: • Antiretroviral therapy..... Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • PCP prophylaxis..... <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 | This patient has been enrolled at: <i>Clinical Trial</i> <i>Clinic</i> <input type="checkbox"/> 1 NIH-sponsored <input type="checkbox"/> 1 HRSA-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unknown <input type="checkbox"/> 9 Unknown This 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"/> 7 Clinical trial/government program <input type="checkbox"/> 9 Unknown |
|--|---|

For women: • This patient is receiving or has been referred for gynecological or obstetrical services..... Yes No Unknown

1 0 9

• This patient is currently pregnant..... Yes No Unknown

1 0 9

• This patient has delivered live born infant(s)..... Yes No Unknown

1 0 9

(If yes, provide birth information below for the most recent birth.)

| | | | |
|---|-------------------|----------------------|---|
| Child's date of birth Month Day Year | Hospital of birth | Child's Soundex | Health Department Use Only Child's state patient number |
| <input type="text"/> | City State | <input type="text"/> | |

X. Comments

MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
 LHD contact information is available on the website: www.dhs.ca.gov/AIDS www.cdph.ca.gov/AIDS