

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	II. Health Department Use Only			
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
					<small>*Publicly funded confidential counseling and testing sites only</small>

III. Demographic Information					
Diagnosis status at report (check one)	Age at Diagnosis Years	Current status	Date of death Month Day Year	State/Territory of death	
1 HIV Infection (not AIDS).....		1 Alive		Country of birth	
2 AIDS.....		2 Dead		1 U.S.	
		9 Unknown		7 U.S. Territories (including Puerto Rico)	
ETHNICITY	RACE			8 Other (specify):	
1 Hispanic	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Black or African American		9 Unknown	
2 Not Hispanic nor Latino	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White			
Expanded race (specify):					
<input type="checkbox"/> 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: <input type="checkbox"/> 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					
Facility name			City	State/Country	
Facility setting (check one)		Facility type (check one)			
1 Public	3 Federal	01 Physician, HMO	29 Community Health Center	31 Hospital, inpatient	88 Other (specify):
2 Private	9 Unknown	22 Counseling and Testing Site	30 Correctional Facility	32 Hospital, outpatient	99 Unknown

V. Patient Risk History (Check all that apply.)									
• Sex with a male.....	Yes	No	Unknown	• Received clotting factor for hemophilia/coagulation disorder	Yes	No	Unknown		
• Sex with a female.....	1	0	9	Specify disorder:	1	0	9		
• Injected nonprescription drugs.....	1	0	9	1 Factor VIII (Hemophilia A)					
				2 Factor IX (Hemophilia B)					
• HETEROSEXUAL relations with any of the following:	Yes	No	Unknown	8 Other (specify):					
• Intravenous/injection drug user.....	1	0	9	• Received transfusion of blood/components (other than clotting factor)	Month	Year	Yes	No	Unknown
• Bisexual male.....	1	0	9	First: Month Year	Month	Year	1	0	9
• Person with hemophilia/coagulation disorder.....	1	0	9	Last: Month Year					
• Transfusion recipient with documented HIV infection.....	1	0	9	• Received transplant of tissue/organs or artificial insemination.	Yes	No	Unknown		
• Transplant recipient with documented HIV infection.....	1	0	9	• Worked in a health care or clinical laboratory setting.....	1	0	9		
• Person with AIDS or documented HIV infection, risk not specified.....	Yes	No	Unknown	(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			C. HIV Viral Load Test (Record earliest test.)						
• HIV-1 EIA.....	Month	Day	Year	Test type*: [] []	Version*: [] []	Month	Day	Year	
• HIV-1/HIV-2 combination EIA.....				Other (specify type and version):					
• Rapid HIV-1 EIA.....				Test result (Record in copies/mL and log ₁₀ values.)					
• HIV-1 Western Blot/IFA.....				<input type="checkbox"/> Detectable	Copies/mL: [] , [] , []				
• Other HIV antibody test.....					Log ₁₀ : [] . []				
(Specify):					Greater than: [] , [] , []	copies/mL			
B. Positive HIV Detection Test (Record earliest test.)	Month	Day	Year	<input type="checkbox"/> Undetectable	Less than: [] []	copies/mL			
<input type="checkbox"/> Culture				* Test type and version: 11 = Nuclisens® HIV-1 QT (Organon-NASBA)					
<input type="checkbox"/> Antigen				12 = Amplicor HIV-1 Monitor® (Roche RT-PCR) version: 1.0 or 1.5					
<input type="checkbox"/> DNA PCR				13 = Bayer/Chiron (bDNA) version: 2.0 or 3.0					
<input type="checkbox"/> RNA PCR				18 = Other (kit name/manufacturer/version)					
<input type="checkbox"/> Other (specify):				D. Immunologic Lab Tests - At or closest to current diagnostic status					
Date of last documented negative HIV test.....	Month	Day	Year	• CD4 count.....	[] , [] []	cells/μl	Month	Day	Year
Specify type:				• CD4 percent.....	[] []	%	[] [] [] []		
Specify facility type (use codes in Section IV):				First <200 μl or <14%					
[01] [22] [29] [30] [31] [32] [99] [88] (Specify):				• CD4 count.....	[] , [] []	cells/μl	Month	Day	Year
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?.....	Yes	No	Unknown	• CD4 percent.....	[] []	%	[] [] [] []		
	1	0	9						
If yes, provide date of documentation by physician.....	Month	Day	Year						

