

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis) *Information NOT transmitted to CDC

I. Patient Identification (record all dates as mm/dd/yyyy)

*First Name		*Middle Name		*Last Name		Last Name Soundex			
Alternate Name Type (ex: Alias, Married)			*First Name		*Middle Name		*Last 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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				*Current Address, Street			Address Date ____/____/____		
*Phone (____) _____		City		County		State/Country		*ZIP Code	
*Medical Record Number				*Social Security Number					
*Has this patient been homeless or unstably housed within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									

II. Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name				*Phone (____) _____			
*Street Address							
City		County		State/Country		*ZIP Code	
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____ <i>Outpatient:</i> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> Other, specify _____ <i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Other, specify _____ <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____							
Date Form Completed ____/____/____		*Person Completing Form			*Phone (____) _____		

III. Patient Demographics (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"/> US <input type="checkbox"/> Other/US dependency (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	
Gender Identity <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Transgender man <input type="checkbox"/> Transgender woman <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					
Sexual Orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown				Expanded Ethnicity	
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown				Expanded Race	

IV. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? <i>If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/____		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Opportunistic Illnesses					
Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary ¹	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary ¹	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

¹ If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number

V. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Pediatric Risk (enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs or shared needles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: _____ Date received ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	
Other documented risk (include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

VI. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays

TEST HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-2 IA

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result Positive Negative Indeterminate Collection Date ____/____/____
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

TEST HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result Overall: Reactive Nonreactive Collection Date ____/____/____
 Analyte results: HIV-1 Ag: Reactive Nonreactive HIV-1/2 Ab: Reactive Nonreactive
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

TEST HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result³ Overall interpretation: Reactive Nonreactive Index Value _____ Collection Date ____/____/____
 Analyte results: HIV-1 Ag: Reactive Nonreactive Not reportable due to high Ab level Index Value _____
 HIV-1 Ab: Reactive Nonreactive Reactive undifferentiated Index Value _____
 HIV-2 Ab: Reactive Nonreactive Reactive undifferentiated Index Value _____
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

TEST HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result⁴ Overall interpretation: HIV positive, untypable HIV-1 positive with HIV-2 cross-reactivity HIV-2 positive with HIV-1 cross-reactivity
 HIV negative HIV indeterminate HIV-1 indeterminate HIV-2 indeterminate HIV-1 positive HIV-2 positive
 Analyte results: HIV-1 Ab: Positive Negative Indeterminate Collection Date ____/____/____
 HIV-2 Ab: Positive Negative Indeterminate
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

TEST HIV-1 WB HIV-1 IFA HIV-2 WB

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result Positive Negative Indeterminate Collection Date ____/____/____
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

HIV Detection Tests

TEST HIV-1/2 RNA NAAT (Qualitative)

Test Brand Name/Manufacturer _____ Lab Name _____
 Facility Name _____ Provider Name _____
 Result HIV-1 HIV-2 Both (HIV-1 and HIV-2) HIV, not differentiated (HIV-1 or HIV-2) Neither (negative)
 Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider² Lab test, self-collected sample

TEST <input type="checkbox"/> HIV-1 RNA NAAT (Qualitative and Quantitative)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result Qualitative: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	Collection Date ____/____/____
Analyte results: HIV-1 Quantitative: <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit	Copies/mL _____ Log _____
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample	
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample	
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit <input type="checkbox"/> Not detected	Copies/mL _____ Log _____
Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample	
Drug Resistance Tests (Genotypic)	
TEST <input type="checkbox"/> HIV-1 Genotype (Unspecified)	Test Brand Name/Manufacturer _____
Lab Name _____	Facility Name _____
Provider Name _____	Collection Date ____/____/____
Immunologic Tests (CD4 count and percentage)	
CD4 count _____ cells/ μ L	CD4 percentage _____ %
Test Brand Name/Manufacturer _____	Collection Date ____/____/____
Facility Name _____	Lab Name _____
	Provider Name _____
Documentation of Tests	
Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If YES, provide date of diagnosis by physician ____/____/____	

²Results not directly observed by a provider should be recorded in HIV Testing History.

³Complete the overall interpretation and the analyte results.

⁴Always complete the overall interpretation. Complete the analyte results when available.

VII. 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	
Has this patient received medical care for their HIV infection?	
<input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 2-Yes, client self-report, only Date of medical visit or prescription ____/____/____	
For Female Patient	
Is this patient currently pregnant? If Yes, add the expected due date.	Has this patient delivered live-born infants?
<input type="checkbox"/> Yes ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)	
*Child's Name _____	Child's Date of Birth ____/____/____
Name of Birth Facility (if child was born at home, enter "home birth") _____	*Phone (____) _____
Facility Type <u>Inpatient:</u>	<u>Outpatient:</u>
<input type="checkbox"/> Hospital	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Other, specify _____	<u>Other Facility:</u> <input type="checkbox"/> Emergency room
	<input type="checkbox"/> Corrections <input type="checkbox"/> Unknown
	<input type="checkbox"/> Other, specify _____

VIII. Antiretroviral Use History (record all dates as mm/dd/yyyy)

Ever taken any ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, reason for ARV use (select all that apply)			
<input type="checkbox"/> HIV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PrEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PMTCT	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> Other (specify reason) _____	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____

IX. HIV Testing History (record all dates as mm/dd/yyyy)

Ever had a previous positive HIV test result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of first positive HIV test result ____/____/____
Was the first positive test result from a self-test performed by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Ever had a negative HIV test result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Date of last negative HIV test result (if date is from a lab test with test type, enter in Lab Data section) ____/____/____	
Was the last negative test result from a self-test performed by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Number of negative HIV test results within the 24 months before the first positive test result ____ <input type="checkbox"/> Unknown	
How many of these negative test results were from self-tests performed by the patient? ____ <input type="checkbox"/> Unknown	

X. Comments
