Reset Form

U.S. Department of Health and Human Services

Adult HIV Confidential Case Report Form

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

Centers for Disease Control and Prevention (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 ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ 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? ☐ Yes ☐ No ☐ 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	*Inpatient*:	*Outpatient*: ☐ Private physician's office	*Screening, Diagnostic, Referral Agency*:	*Other Facility*: ☐ Emergency room
	☐ Hospital	☐ Adult HIV clinic	☐ CTS ☐ STD clinic	☐ Laboratory ☐ Corrections ☐Unknown
	☐ Other, specify _____	☐ Other, specify _____	☐ Other, specify _____	☐ Other, specify _____

Date Form Completed ____/____/_____	*Person Completing Form	*Phone ( )

III. Patient Demographics (record all dates as mm/dd/yyyy)

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US dependency (specify)	
Date of Birth ____/____/_____	Alias Date of Birth ____/____/_____	
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death ____/____/_____	State of Death
Gender Identity	☐ Man ☐ Woman ☐ Transgender man ☐ Transgender woman ☐ Unknown ☐ Other (specify) _____	
Sexual Orientation	☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Unknown ☐ Other (specify) _____	
Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity
Race (check all that apply)	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race

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

Suspect acute HIV infection? *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*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/_____	☐ Yes ☐ No ☐ 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	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs or shared needles	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received ____/____/_____	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received ____/____/_____ Last date received ____/____/_____	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ 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)	☐ Yes ☐ No ☐ 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 provider[2] ☐ 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 provider[2] ☐ 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**_____
Result[3] ***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 provider[2] ☐ 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**_____
Result[4] ***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 provider[2] ☐ 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 provider[2] ☐ Lab test, self-collected sample

HIV Detection Tests

TEST ☐ HIV-1/2 RNA NAAT (Qualitative) **Lab Name**_____
Test Brand Name/Manufacturer_____ **Provider Name**_____
Facility Name_____ **Collection Date** ____/____/_____
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 provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA NAAT (Qualitative and Quantitative)
Test Brand Name/Manufacturer_____ **Lab Name**_____
Facility Name_____ **Provider Name**_____
Result ***Qualitative:*** ☐ Reactive ☐ Nonreactive **Collection Date** ____/____/_____
Analyte results: HIV-1 Quantitative*:* ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit
Copies/mL_____ **Log**_____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
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 provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA/DNA NAAT (Quantitative) ☐ HIV-2 RNA/DNA NAAT (Quantitative)
Test Brand Name/Manufacturer_____ **Lab Name**_____
Facility Name_____ **Provider Name**_____
Result ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit ☐ Not detected **Copies/mL**_____ **Log**_____
Collection Date __ __ /__ __ / _____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

Drug Resistance Tests (Genotypic)

TEST ☐ 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/µL **CD4 percentage** _____ % **Collection Date** ____/____/_____
Test Brand Name/Manufacturer_____ **Lab Name**_____
Facility Name **Provider Name**

Documentation of Tests

Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis by physician __ __ /__ __ /_____

[2] Results not directly observed by a provider should be recorded in HIV Testing History.
[3] Complete the overall interpretation and the analyte results.
[4] Always 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? ☐ Yes ☐ No ☐ Unknown

Has this patient received medical care for their HIV infection?
☐ 1-Yes, documented ☐ 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.
☐ Yes __ __ /__ __ /__ __ ☐ No ☐ Unknown

Has this patient delivered live-born infants?
☐ Yes ☐ No ☐ 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 *Inpatient:*
☐ Hospital
☐ Other, specify_____

Outpatient:
☐ Other, specify _____

Other Facility: ☐ Emergency room
☐ Corrections ☐ Unknown
☐ Other, specify

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

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications_____	Date began ____/____/_____	Date of last use ____/____/_____
☐ PrEP	ARV medications _____	Date began ____/____/_____	Date of last use ____/____/_____
☐ PEP	ARV medications_____	Date began ____/____/_____	Date of last use ____/____/_____
☐ PMTCT	ARV medications_____	Date began ____/____/_____	Date of last use ____/____/_____
☐ 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? ☐ Yes ☐ No ☐ Unknown **Date of first positive HIV test result** ____/____/_____
Was the first positive test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown

Ever had a negative HIV test result? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No ☐ Unknown

Number of negative HIV test results within the 24 months before the first positive test result ____ ☐ Unknown
How many of these negative test results were from self-tests performed by the patient? ____ ☐ Unknown

X. Comments