

ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

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: ☐ 1- New ☐ 2- Update	Physician's Name:		Physician's Phone Number: ()	Hospital/Facility Name:
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Surveillance Method: ☐ Active ☐ Passive ☐ Follow Up ☐ Reabstraction ☐ Unknown		Report Medium: ☐ 1- Field Visit ☐ 2- Mailed ☐ 3- Phone ☐ 4- Electronic Transfer ☐ 5- CD/Disk	

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: ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ 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:

III. Patient Demographics (See Appendix 2.0 for Further Details) (Record All Dates as mm/dd/yyyy)

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other/U.S. Dependency (please specify): _____		Date of Birth: ____/____/____	
Alias Date of Birth: ____/____/____	Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: ____/____/____	State of Death:	Status: ☐ HIV ☐ AIDS
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male-to-Female (MTF) ☐ Transgender: Female-to-Male (FTM) ☐ Unknown ☐ Other Gender Identity (specify): _____			Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ Chinese ☐ Vietnamese ☐ Hawaiian ☐ Japanese ☐ Asian Indian ☐ Guamanian ☐ Filipino ☐ Laotian ☐ Samoan ☐ Korean ☐ Cambodian ☐ Other (specify): _____	
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity:			
Expanded Race:				

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 (check all that apply): ☐ Residence at HIV Diagnosis ☐ Residence at AIDS Diagnosis ☐ Check if SAME as Current Address				
Address of Residence at HIV Diagnosis	Street Address:	City:	County:	State/Country:
Address of Residence at AIDS Diagnosis	Street Address:	City:	County:	State/Country:
				ZIP Code:

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

Diagnosis Type (check all that apply to facility): ☐ HIV Diagnosis ☐ AIDS Diagnosis ☐ 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> ☐ Hospital ☐ Other (specify): _____		
	<u>Outpatient:</u> ☐ Private Physician ☐ Adult HIV Clinic ☐ Other (specify): _____		
	<u>Screening, Diagnostic, Referral Agency:</u> ☐ CTS ☐ STD Clinic ☐ Other (specify): _____		
	<u>Other Facility:</u> ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other (specify): _____		

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: ☐ Yes ☐ No ☐ Unknown	Sex with a female: ☐ Yes ☐ No ☐ Unknown	Injected non-prescription drugs: ☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	Has the patient:	
Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown	Received clotting factor for hemophilia/coagulation disorder: ☐ Yes ☐ No ☐ Unknown	
Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown	Received transfusion of blood/blood components (non-clotting): ☐ Yes ☐ No ☐ Unknown	
Contact with a person with AIDS or documented HIV infection, risk not specified: ☐ Yes ☐ No ☐ Unknown	Other documented risk: ☐ Yes ☐ No ☐ Unknown	
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	(if yes, specify): _____	
Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	_____	

VII. Laboratory Data (Record All Dates as mm/dd/yyyy) (See Instructions for Details)

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]	
TEST 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): _____	
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): ☐ Collection Date: ____/____/____
TEST 2: ☐ 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): _____	
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): ☐ Collection Date: ____/____/____
TEST 3: ☐ 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): _____	
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): ☐ Collection Date: ____/____/____
HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]	
TEST: ☐ HIV-1/2 Differentiating (e.g. Multispot)	
RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) Collection Date: ____/____/____	

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

STATENO: _____

HIV Detection Tests (Qualitative)			
TEST 1: ☐ HIV-1 RNA/DNA NAAT (<i>Qual</i>) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (<i>Qual</i>) ☐ HIV-2 Culture			
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate		Collection Date: ____/____/____	
TEST 2: ☐ HIV-1 RNA/DNA NAAT (<i>Qual</i>) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (<i>Qual</i>) ☐ HIV-2 Culture			
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate		Collection Date: ____/____/____	
HIV Detection Tests (Quantitative Viral Load) <i>Note: Include earliest test after diagnosis</i>			
TEST 1: ☐ HIV-1 RNA/DNA NAAT (<i>Quantitative Viral Load</i>) ☐ RT-PCR ☐ bDNA ☐ Other (<i>specify test</i>): _____			
RESULT: ☐ Detectable ☐ Undetectable Copies/mL: _____		Log: _____ Collection Date: ____/____/____	
TEST 2: ☐ HIV-1 RNA/DNA NAAT (<i>Quantitative Viral Load</i>) ☐ RT-PCR ☐ bDNA ☐ Other (<i>specify test</i>): _____			
RESULT: ☐ Detectable ☐ Undetectable Copies/mL: _____		Log: _____ Collection Date: ____/____/____	
Immunologic Tests (CD4 Count and Percentage)			
CD4 at or closest to current diagnosis status: CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____			
First CD4 result <200 cells/μL or <14%:		CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____	
Other CD4 result <200 cells/μL or <14%:		CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____	
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? ☐ Yes ☐ No ☐ Unknown If yes, provide date (<i>specimen collection date if known</i>) of earliest positive test for this algorithm: ____/____/____			
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown If yes, provide date of documentation by physician: ____/____/____			

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 (<i>specify</i>):		

IX. Treatment/Services Referrals (Record All Dates as mm/dd/yyyy)

Has This Patient Been Informed of His/Her HIV Infection? ☐ Yes ☐ No ☐ Unknown	
Patient's Medical Treatment is Primarily Reimbursed by: ☐ 1- Medicaid ☐ 2- Private Insurance/HMO ☐ 3- No Coverage ☐ 4- Other Public Funding ☐ 9- Unknown	
For Female Patient:	
Is This Patient Currently Pregnant? ☐ Yes ☐ No ☐ Unknown	Has This Patient Delivered Live-Born Infants? ☐ Yes ☐ No ☐ Unknown

IX. Treatment/Services Referrals (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____

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

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 (select one): ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other (specify): _____			Date Patient Reported Information: ____/____/____
Ever Had a Positive HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of First Positive HIV Test: ____/____/____	Ever Had a Negative HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of Last Negative HIV Test: (If date is from a lab test with test type, enter in Laboratory Data Section.) ____/____/____
Number of Negative HIV Tests Within 24 Months Before First Positive Test (#): _____ ☐ Refused ☐ Don't Know/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: ____/____/____		Date ARVs Last Taken (mm/dd/yyyy): ____/____/____	

XI. Duplicate Review

Status (check one): ☐ Same As ☐ Different Than ☐ Pending	State Name:	STATENO:
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XII. Comments and Local/Optional Fields

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LOCAL HEALTH DEPARTMENTS:

SUBMIT COMPLETED FORM TO THE OFFICE OF AIDS PER YOUR CONTRACT'S SCOPE OF WORK, EXHIBIT A, PART D, OBJECTIVE 2.

PROVIDERS:

SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.

Local Health Department HIV/AIDS contact list is available at: www.cdph.ca.gov/programs/AIDS/pages/TOAHIVRptgSP.aspx