

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		*Other ID Type Social Security			*Number

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 CDCCenters for Disease Control
and Prevention (CDC)**Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 11/30/2022

Date Received at Health Department ____/____/____	eHARS Document UID	State Number
Reporting Health Dept—City/County		City/County Number
Document Source	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 6-CD/disk	

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

Facility Name		*Phone (____)	
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	<u>Inpatient:</u> ☐ Hospital ☐ Other, specify _____ <u>Outpatient:</u> ☐ Private physician's office ☐ 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 _____		
Date Form Completed ____/____/____	*Person Completing Form		*Phone (____)

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

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown		Country of Birth ☐ US ☐ Other/US dependency (please specify) _____	
Date of Birth ____/____/____		Alias Date of Birth ____/____/____	
Vital Status ☐ 1-Alive ☐ 2-Dead		Date of Death ____/____/____	State of Death
Current Gender Identity ☐ Male ☐ Female ☐ Transgender male-to-female (MTF) ☐ Transgender female-to-male (FTM) ☐ Unknown ☐ Additional gender identity (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

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if <u>SAME</u> as current address			
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary			
*Street Address			
City	County	State/Country	*ZIP Code

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

STATE/LOCAL USE ONLY	
*Provider Name (Last, First, M.I.)	*Phone ()
Hospital/Facility	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Check if <u>SAME</u> as facility providing information			
Facility Name			*Phone ()
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type <u>Inpatient:</u> ☐ Hospital <u>Outpatient:</u> ☐ Private physician's office <u>Screening, Diagnostic, Referral Agency:</u> <u>Other Facility:</u> ☐ Emergency room ☐ Other, specify _____ ☐ Adult HIV clinic ☐ CTS ☐ STD clinic ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____ ☐ Other, specify _____ ☐ Other, specify _____ ☐ Other, specify _____			
*Provider Name		*Provider Phone ()	Specialty

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ **Pediatric Risk (please 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	☐ 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 intravenous/injection drug user	☐ 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 (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

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 data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.</i>	☐ 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
Other evidence suggestive of acute HIV infection? <i>If YES, please describe:</i> Date of evidence ____/____/____	☐ 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	

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

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

HIV Immunoassays (Nondifferentiating)		
TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB		
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Result ☐ Positive ☐ Negative ☐ Indeterminate		Collection Date ____/____/____ ☐ Point-of-care rapid test
TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB		
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Result ☐ Positive ☐ Negative ☐ Indeterminate		Collection Date ____/____/____ ☐ Point-of-care rapid test
HIV Immunoassays (Differentiating)		
☐ HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)		Role of test in diagnostic algorithm ☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Result ¹ Overall interpretation: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative		Collection Date ____/____/____ ☐ Point-of-care rapid test
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate		¹ Always complete the overall interpretation. Complete the analyte results when available.
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate		
☐ 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 ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid		
Collection Date ____/____/____ ☐ Point-of-care rapid 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 ² Overall interpretation: ☐ Reactive ☐ Nonreactive ☐ Index value _____		
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 _____
Collection Date ____/____/____ ☐ Point-of-care rapid test		² Complete the overall interpretation and the analyte results.
HIV Detection Tests (Qualitative)		
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 ____/____/____
HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis.		
TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)		
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Result ☐ Detectable ☐ Undetectable Copies/mL _____		Log _____ Collection Date ____/____/____
TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)		
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Result ☐ Detectable ☐ Undetectable Copies/mL _____		Log _____ Collection Date ____/____/____
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 at or closest to diagnosis: CD4 count _____ cells/μL		CD4 percentage _____ % Collection Date ____/____/____
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
First CD4 result <200 cells/μL or <14%: CD4 count _____ cells/μL		CD4 percentage _____ % Collection Date ____/____/____
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Other CD4 result: CD4 count _____ cells/μL		CD4 percentage _____ % Collection Date ____/____/____
Test brand name/Manufacturer _____		Lab name _____
Facility name _____		Provider name _____
Documentation of Tests		
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown		
If YES, provide specimen collection date of earliest positive test for this algorithm ____/____/____		
Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.		
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown		
If YES, provide date of diagnosis ____/____/____		
Date of last documented negative HIV test (before HIV diagnosis date) ____/____/____		
Specify type of test: _____		

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown		This patient's partners will be notified about their HIV exposure and counseled by ☐ 1-Health dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown	
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) ☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription ____/____/____			
For Female Patient			
This patient is receiving or has been referred for gynecological or obstetrical services ☐ Yes ☐ No ☐ Unknown		Is this patient currently pregnant? ☐ 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 ____/____/____	
Child's Last Name Soundex		Child's State Number	
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone ()	
Facility Type <u>Inpatient:</u> ☐ Hospital ☐ Other, specify _____		<u>Outpatient:</u> ☐ Other, specify _____	
		<u>Other Facility:</u> ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____	
*Street Address		*ZIP Code	
City	County	State/Country	

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

Main source of antiretroviral (ARV) use information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other			Date patient reported information ____/____/____
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 ____/____/____
☐ HBV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
☐ Other (specify reason) _____			
	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____

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

Main source of testing history information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other		Date patient reported information ____/____/____
Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown	Date of first positive HIV test ____/____/____	
Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown	Date of last negative HIV test (if date is from a lab test with test type, enter in Lab Data section) ____/____/____	
Number of negative HIV tests within the 24 months before the first positive test ____ ☐ Unknown		

Comments

CHECK OOS STATE: _____	If pregnant, list EDD(due date): ____/____/____
Link With e-HARS stateno(s): _____	

Local/Optional Fields*NIR STATUS:**

STARS# _____	DOC# _____	NIR OP ____ Date ____/____/____
Other Risks: A ____ B/C ____ D ____ F ____ M ____ V ____ J ____ O ____		NIR CL ____ Date ____/____/____
Hepatitis: A ____ B ____ C ____ Other ____ Unknown ____		NIR RE ____ Date ____/____/____
Test and Treat (Yes/No): _____		Initials(3) _____ Source code: _____

This report to CDC is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal-government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).