

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				*Other ID Type			*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)**II. Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no.0920-0573 Exp. 02/28/2026

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

III. 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:		Screening, Diagnostic, Referral Agency:		Other Facility:	
<input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<input type="checkbox"/> Private physician's office <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> Other, specify _____		<input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Other, specify _____		<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 ()			

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

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown/Undetermined		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	
Sexual Orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Additional sexual orientation (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown					
Date Identified ____/____/____					
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	

V. 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) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Check if <u>SAME</u> as current address							
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							
*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.**

VI. Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) HIV Stage 3 (AIDS) Check if SAME as facility providing information

Facility Name _____ ***Phone** () _____

***Street Address** _____

City	County	State/Country	*ZIP Code
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Facility Type *Inpatient:* Hospital Other, specify _____ *Outpatient:* Private physician's office Adult HIV clinic Other, specify _____ *Screening, Diagnostic, Referral Agency:* CTS STD clinic Other, specify _____ *Other Facility:* Emergency room Laboratory Corrections Unknown Other, specify _____

***Provider Name** _____ ***Provider Phone** () _____ **Specialty** _____

VII. 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	<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) First date received ___/___/_____ Last date received ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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

VIII. 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

Other evidence suggestive of acute HIV infection? *If YES, describe:* _____ 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.

IX. 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

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

TEST <input type="checkbox"/> 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: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-1/2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		
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-1/2 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: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index Value _____	Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level Index Value _____ HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____ HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____		
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-1/2 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: <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-1 positive with HIV-2 cross-reactivity <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity <input type="checkbox"/> HIV negative <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive	Collection Date ____/____/____	
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Collection Date ____/____/____ HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
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 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 WB		
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		
HIV Detection Tests		
TEST <input type="checkbox"/> HIV-1/2 RNA NAAT (Qualitative)		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (HIV-1 and HIV-2) <input type="checkbox"/> HIV, not differentiated (HIV-1 or HIV-2) <input type="checkbox"/> Neither (negative)	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 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)		
Lab Name _____	Test Brand Name/Manufacturer _____	
Provider Name _____	Facility Name _____	
	Collection Date ____/____/____	
Immunologic Tests (CD4 count and percentage)		
CD4 count _____ cells/ μ L	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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If YES, provide specimen collection date of earliest positive test result for this algorithm ____/____/____		
<i>Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.</i>		
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 ____/____/____		
Date of last documented negative HIV test result (before HIV diagnosis date) ____/____/____		
Specify type of test: _____		
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		

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.

X. 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		This patient's partners will be notified about their HIV exposure and counseled by <input type="checkbox"/> 1-Health dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown	
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) <input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has this patient delivered live-born infants? <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 ___/___/_____	
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 <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
*Street Address _____		*ZIP Code _____	
City _____	County _____	State/Country _____	

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

Main source of antiretroviral (ARV) use information (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			Date patient reported information ___/___/_____
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"/> HBV Tx	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> Other (specify reason) _____	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____

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

Main source of testing history information (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			Date patient reported information ___/___/_____
Ever had 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			

XIII. Comments

CHECK OOS STATE: _____	If pregnant, list EDD (due date): ___/___/_____
DOC# _____	
Link with e-HARS stateno(s): _____	

XIV. *Local/Optional Fields

STARS# _____	NIR OP _____	Date: ___/___/_____	NIR Status: _____
Other Risks: A B/C D F M V J O	NIR CL _____	Date: ___/___/_____	
Hepatitis: A B C Other UNKnown	NIR RE _____	Date: ___/___/_____	
Test & 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, 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).