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)

Form approved OMB no. 0920-0573 Exp. 04/30/2026

*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 | *Number

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

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

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:
- ○ 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

Date Form Completed (/ /) | *Person Completing Form | *Phone

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

Sex
- ○ Male
- ○ Female
- ○ Unknown/Undetermined

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

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.**

Sexual Orientation

○ Straight or heterosexual ○ Declined to answer
○ Lesbian or gay ○ Unknown
○ Bisexual
○ Additional sexual orientation (specify) _____

Date Identified ___/___/___

Ethnicity ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Unknown

Expanded Ethnicity _____

Race (check all that apply)

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ White
☐ Black/African American ☐ 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)

☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address

Address Type

○ Residential ○ Military
○ Bad address ○ Other
○ Correctional facility ○ Postal
○ Foster home ○ Shelter
○ Homeless ○ Temporary

***Street Address** _____

City _____ **County** _____

State/Country _____ ***ZIP Code** _____

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** _____

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	○ 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

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).

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

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

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

Acute HIV Infection

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
Candidiasis, bronchi, trachea, or lungs	
Candidiasis, esophageal	
Carcinoma, invasive cervical	
Coccidioidomycosis, disseminated or extrapulmonary	
Cryptococcosis, extrapulmonary	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	
Cytomegalovirus retinitis (with loss of vision)	
HIV encephalopathy	
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis	
Histoplasmosis, disseminated or extrapulmonary	
Isosporiasis, chronic intestinal (>1 mo. duration)	
Kaposi's sarcoma	

Diagnosis	Dx Date
Lymphoma, Burkitt's (or equivalent)	
Lymphoma, immunoblastic (or equivalent)	
Lymphoma, primary in brain	
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
M. tuberculosis, pulmonary[1]	
M. tuberculosis, disseminated or extrapulmonary[1]	
Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Pneumocystis pneumonia	
Pneumonia, recurrent, in 12 mo. period	
Progressive multifocal leukoencephalopathy	
Salmonella septicemia, recurrent	
Toxoplasmosis of brain, onset at >1 mo. of age	
Wasting syndrome due to HIV	

[1]If 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 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

Analyte results:
HIV-1 Ag:
○ Reactive
○ Nonreactive

HIV-1/2 Ab:
○ Reactive
○ Nonreactive

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 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 _____

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 ___/___/_____

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

HIV-2 Ab:
○ 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 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)

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)

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 NAAT (Qualitative and Quantitative)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
Qualitative:
○ Reactive
○ Nonreactive

Analyte results:
HIV-1 Quantitative
○ Detectable above limit
○ Detectable within limits
○ Detectable below limit

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

TEST ○ HIV-1 RNA/DNA NAAT (Qualitative) ○ HIV-2 RNA/DNA NAAT (Qualitative) ○ HIV-1 culture ○ 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

*Complete 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.*

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ○ Yes ○ No ○ Unknown

If YES, provide specimen collection date of earliest positive test result for this algorithm ____/____/_____

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 ____/____/_____

Date of last documented negative HIV test result (before HIV diagnosis date) ____/____/_____

Specify type of test: _____

Testing Option (if applicable)
○ Point-of-care test by provider ○ Self-test, result directly observed by a provider[2] ○ Lab test, self-collected sample

[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.

X. 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

Inpatient: ○ Hospital ○ Other, specify

Outpatient: ○ Other, specify

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

*Street Address | City

County | State/Country | *ZIP Code

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

Main source of antiretroviral (ARV) use information (select one)
○ Patient interview ○ Provider report ○ Other
○ Medical record review ○ NHM&E

Date patient reported information (/ /)

Ever taken any ARVs? ○ Yes ○ No ○ Unknown

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

	ARV medications	Date began (/ /)	Date of last use (/ /)
☐ HIV Tx			
☐ PrEP			
☐ PEP			
☐ PMTCT			
☐ HBV Tx			
☐ Other (specify reason)			

XII. 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 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

XIII. Comments

XIV. *Local/Optional Fields