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 Identifi								
*First Name	*Mic	ddle Name	*Last Name		Last	Name Soundex		
Alternate Name Type (ex: Alias, Married)		*First Name	*Middle l	*Middle Name		*Last Name		
Address Type Residential Bad address	Correctional facility Foster home	Homeless Military	Other Postal	_	nelter			
*Current Address, Stre	eet				A	Address Date / /		
*Phone C	ity	County	Si	tate/Country		*ZIP Code		
*Medical Record Num	ber	*Other ID Type		*Number				
II. Health Depart	ment Use Only	(record all dates as mm/do	i/yyyy)					
Date Received at Heal	th Department	eHARS Document	UID	Sta	ate Number			
Reporting Health Dept	-City/County		City/Count	y Number				
Document Source		Surveillance Metho Active		Follow up	Reabstracti	on Unknown		
Did this report initiate	a new case investiga	ation? Report Medium						
Yes No	Unknown	1-Field visit	3-Faxed		5-Electronic tr	ansfer		
103 140		2-Mailed	4-Phone		6-CD/disk			
	ding Informatio	2-Mailed  (record all dates as mm			6-CD/disk			
III. Facility Provi	ding Informatio				6-CD/disk	*Phone		
III. Facility Provi	ding Informatio		/dd/yyyy)	City	6-CD/disk	*Phone		
	ding Informatio		/dd/yyyy)	City	6-CD/disk	*Phone  *ZIP Code		
III. Facility Provide Facility Name *Street Address	Outpat	State/Country	/dd/yyyy)	ostic,	Other Fa	*ZIP Code		
III. Facility Provide Facility Name Street Address County Facility Type	<u>Outpat</u> Priv	n (record all dates as mm	/dd/yyyy)  Screening, Diagn Referral Agency: CTS	ostic,	<u>Other Fa</u> Emer	*ZIP Code		
III. Facility Provide Facility Name Street Address County Facility Type Inpatient:	<u>Outpat</u> Priv Adu	State/Country  tient: vate physician's office	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre	*ZIP Code  acility: rgency room ratory ections		
III. Facility Provide Facility Name  *Street Address  County  Facility Type  Inpatient:  Hospital	<u>Outpat</u> Priv Adu	State/Country  tient: vate physician's office ult HIV clinic	/dd/yyyy)  Screening, Diagn Referral Agency: CTS	ostic.	Other Fa Emer Labo Corre Unkn	*ZIP Code  acility: rgency room ratory ections		
III. Facility Provide Facility Name  *Street Address  County  Facility Type  Inpatient:  Hospital Other, specify	<u>Outpat</u> Priv Adu Oth	State/Country  tient: vate physician's office ult HIV clinic	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre Unkn	*ZIP Code  acility: gency room ratory ections lown		
III. Facility Provide Facility Name  Street Address  County  Facility Type  Inpatient:  Hospital Other, specify  Date Form Completed	Outpat Priv Adu Oth	State/Country  tient: vate physician's office ult HIV clinic ner, specify	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre Unkn	*ZIP Code  *ZIP Code  *Cility:  **gency room  ratory  ections  own  r, specify		
III. Facility Provide Facility Name  *Street Address  County  Facility Type  Inpatient:  Hospital Other, specify  Date Form Completed	Outpai Priv Adu Oth *Person	State/Country  tient: vate physician's office ult HIV clinic ner, specify  n Completing Form	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre Unkn Othe	*ZIP Code  *cility: gency room ratory ections own r, specify  *Phone		
III. Facility Provide Facility Name  *Street Address  County  Facility Type Inpatient: Hospital Other, specify  Date Form Completed  IV. Patient Demo Sex Assigned at Birth US	Outpate Priv Adu Oth *Person  graphics (record Male Fe	State/Country  tient: vate physician's office ult HIV clinic her, specify  n Completing Form  all dates as mm/dd/yyyy)	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre Unkn Othe	*ZIP Code  *ZIP Code  *Cility:  **gency room  ratory  ections  own  r, specify		
III. Facility Provide Facility Name  *Street Address  County  Facility Type  Inpatient:  Hospital Other, specify  Date Form Completed  IV. Patient Demo  Sex Assigned at Birth Country of Birth	Outpate Priv Adu Oth *Person  graphics (record Male Fe	State/Country  tient: vate physician's office ult HIV clinic ner, specify  n Completing Form  all dates as mm/dd/yyyy) male Unknown	Screening, Diagn Referral Agency: CTS STD clinic	ostic.	Other Fa Emer Labo Corre Unkn Othe	*ZIP Code  *cility: gency room ratory ections own r, specify  *Phone		

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.

Gender Ident	tity							Date Ide	ntified
Man								/	/
Woman	·		gender identity (s	specify)					
Transgend Transgend	der man der woman	Declined to Unknown	o answer						
		•						Date Ider	-±ifiod
Sexual Orien		n Doclino	d to answer					Date luci	ntineu /
Lesbian o	r heterosexua r aav	u Declined Unknow							<i>J</i>
Bisexual									
Additiona	l sexual orient	tation (specify)							
Ethnicity	Hispanic/L	.atino Not	Hispanic/Latino	Unknov	wn		Expanded Ethnicity		
Race	American	Indian/Alaska N	lative	Native Haw	raiian/Other Pacific Isla	ander	Expanded Race		
(check all that apply)	Asian			White					
	Black/Afri	can American	J	Unknown					
W Depide	4 Dia								
					omments) (record all o	dates as m	ım/dd/yyyy)		
Residence	e at HIV diagn	117		dence at sta	age 3 (AIDS) diagnosis	<b>i</b>	Check if <u>SAME</u> as cu	irrent address	3
Address Type Residentia		Military	*Street Addre	SS					
Bad addre		Other							
Correction		Postal	City			C	County		
Foster ho	•	Shelter							
Homeless	3	Temporary	State/Country	У				*ZIP Code	
VI. Facilit	y of Diagi	nosis (add ad	Iditional facilities	s in Comme	ents)				
Diagnosis Ty	<b>pe</b> (check all t	that apply to fac	cility below)	HIV	Stage 3 (AIDS)	Chec	k if <u>SAME</u> as facility pro	oviding inforn	nation
Facility Name	e							*Phone	
-									
*Street Addre	ess					City			
County			;	State/Cour	ntry			*ZIP Co	ode
Facility Type		<u>Outpatie</u>	<u>nt:</u>		Screening, Diagnost	tic,	Other Fac	<u>:ility</u> :	
Inpatient:			te physician's offi	ice	Referral Agency:		-	gency room	
Hospital	:¢		HIV clinic		CTS STD clinic		Labora	•	
Other, spe	ecity	Other	r, specify		Other, specify		Correc Unkno		
					Other, specify			specify	
*Provider Na	me			*Provid	ler Phone Specia	alty			
VII. Patie	4 1 1 1 4			ord all date	es as mm/dd/vvvv)		Pediatric F	Risk (enter in	n Comments
	nt History	(respond to al	l questions) (rec						
After 1977					on, this patient had:				
After 1977 Sex with m	and before th						Yes	No Un	known
Sex with m	and before that								
Sex with m	and before the	ne earliest knov					Yes	No Un	known
Sex with m Sex with fe Injected no	and before the ale emale emprescription	ne earliest knov		HIV infectio			Yes	No Un	

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).

Date received

Specify clotting factor:

Yes

No

Unknown

		gnosis of HIV infe					
HETEROSEXUAL relati	ions with any of the	e following:					
HETEROSEXUAL conta	act with person who	injected drugs			Yes	No	Unknown
HETEROSEXUAL contact with bisexual male					Yes	No	Unknown
HETEROSEXUAL conta	act with person with	hemophilia/coag	ulation disor	der with documented HIV infection	Yes	No	Unknown
HETEROSEXUAL conta	act with transfusion	recipient with do	cumented H	IIV infection	Yes	No	Unknown
HETEROSEXUAL conta	act with transplant re	ecipient with doc	cumented HI	V infection	Yes	No	Unknown
HETEROSEXUAL conta	act with person with	documented HI\	V infection, i	isk not specified	Yes	No	Unknown
Received transfusion of	blood/blood compo	onents (other than	clotting fac	tor) (document reason in Comments)	Yes	No	Unknown
First date received	1 1	Last date	received	/ /			
Received transplant of	tissue/organs or art				Yes	No	Unknown
Worked in a healthcare			011		Yes	No	Unknown
If occupational exposur		• •	ed as primar	mode of exposure,			
specify occupation and			•	, ,			
Other documented risk	(include detail in Co	omments)			Yes	No	Unknown
Acute HIV Infection				Illinesses (record all dates as mr			
result data in Laboratory result in HIV Testing His	y Data section, and e story section	enter patient or pr	rovider repor	t of previous negative HIV test	Yes	No	Unknown
pharyngitis, rash, lymp	hadenopathy)?	cute retroviral sy	ndrome (e.g	., fever, malaise/fatigue, myalgia,	Yes	No	Unknown
Date of sign/symptom		<u> </u>					
Other evidence sugges	stive of acute HIV inf	fection?			Yes	No	Unknown
If YES, describe:	1 1						
Date of evidence	<i>]</i>						
Opportunistic Illnesses							
Diagnosis			Dx Date	Diagnosis			Dx Date
Diagnosis Candidiasis, bronchi, tr	rachea, or lungs		Dx Date	Diagnosis  Lymphoma, Burkitt's (or equivale	nt)		Dx Date
-			Dx Date		•		Dx Date
Candidiasis, bronchi, tr	al		Dx Date	Lymphoma, Burkitt's (or equivale	•		Dx Date
Candidiasis, bronchi, tr Candidiasis, esophagea Carcinoma, invasive ce Coccidioidomycosis, di	al ervical isseminated or extra		Dx Date	Lymphoma, Burkitt's (or equivale	ųuivalent)	j,	Dx Date
Candidiasis, bronchi, tr Candidiasis, esophagea Carcinoma, invasive ce Coccidioidomycosis, dia Cryptococcosis, extrap	al ervical isseminated or extra pulmonary	pulmonary	Dx Date	Lymphoma, Burkitt's (or equivale Lymphoma, immunoblastic (or ed Lymphoma, primary in brain Mycobacterium avium complex of	ųuivalent)	i,	Dx Date
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Candidiasis, bronchi, tr Candidiasis, esophagea Carcinoma, invasive ce Coccidioidomycosis, dia Cryptococcosis, extrap Cryptosporidiosis, chro Cytomegalovirus diseasor nodes)	al ervical isseminated or extra pulmonary onic intestinal (>1 mo	o. duration) er, spleen,	Dx Date	Lymphoma, Burkitt's (or equivale Lymphoma, immunoblastic (or ed Lymphoma, primary in brain Mycobacterium avium complex of disseminated or extrapulmonary M. tuberculosis, pulmonary	pr M. kansasii	ury <sup>1</sup>	Dx Date
Candidiasis, bronchi, tr Candidiasis, esophagea Carcinoma, invasive ce Coccidioidomycosis, dia Cryptococcosis, extrap Cryptosporidiosis, chro Cytomegalovirus diseas or nodes)	al ervical isseminated or extra pulmonary onic intestinal (>1 mo	o. duration) er, spleen,	Dx Date	Lymphoma, Burkitt's (or equivale Lymphoma, immunoblastic (or ed Lymphoma, primary in brain Mycobacterium avium complex of disseminated or extrapulmonary M. tuberculosis, pulmonary M. tuberculosis, disseminated or Mycobacterium, of other/unident	pr M. kansasii	ury <sup>1</sup>	Dx Date
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Test Brand Name/M		b differentiating immu	unoassay (differentiates b Lab Name	petween HIV Ag and HIV Ab)
Facility Name			Provider Name	
	Reactive	7-1/2 Ab: Reactive Nonreactive	Collection Date	<b>Testing Option</b> (if applicable)  Point-of-care test by provider  Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample
TEST Test Brand Name/M		differentiating immur	noassay (differentiates an Lab Name	nong HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Facility Name			Provider Name	
Result <sup>3</sup> 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
TEST Test Brand Name/Ma		ting immunoassay (s	supplemental) (differentia Lab Name	ates between HIV-1 Ab and HIV-2 Ab)
Facility Name			Provider Name	
Result <sup>4</sup> Overall interpretation HIV positive, unty HIV-1 positive with HIV-2 cross-react HIV-2 positive with HIV-1 cross-react HIV negative	pable HIV indeterminate n HIV-1 indeterminat ivity HIV-2 indeterminat h HIV-1 positive	e Negat	HIV-2 Ab: ve Positive	Collection Date  Testing Option (if applicable)  Point-of-care test by provider  Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample
Test Brand Name/M	TEST anufacturer	HIV-1 WB	HIV-1 IFA HIV-2 Lab Name	
Facility Name			Provider Name	
Result Positive Negative Indeterminate		Colle	ction Date	Testing Option (if applicable)  Point-of-care test by provider  Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample
HIV Detection Test		TEST HIV-1/2 F	RNA NAAT (Qualitative)	
Facility Name			Provider Name	
Result HIV-1 HIV-2 Both (HIV-1 and H	HIV, not differentia (HIV-1 or HIV-2) Neither (negative)	,	ction Date	<b>Testing Option</b> (if applicable)  Point-of-care test by provider  Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample
Test Brand Name/Ma	<b>TEST</b> anufacturer	HIV-1 RNA NA	AT (Qualitative and Qua Lab Name	ntitative)
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		<b>Testing Option</b> (if applicable)  Point-of-care test by provider  Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample

	-1 RNA/DNA NAAT (Q	•	RNA/DNA NAAT (Qualitative) culture
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	
Result			Testing Option (if applicable)
Positive Collection	on Date/		Point-of-care test by provider
Negative Indeterminate			Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample
	DNA NAAT (Quantitati	ve) HIV-2 RNA/D	NA NAAT (Quantitative)
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	
Result	00/ml		
Detectable above limit  Detectable within limits	es/mL	_	Testing Option (if applicable)
Detectable within limits  Detectable below limit	Log	_	Point-of-care test by provider Self-test, result directly observed by a provider <sup>2</sup>
Not detected Collectio	n Date/		Lab test, self-collected sample
Drug Resistance Tests (Genotypic)	TEST HIV-1 G	enotype (Unspecified)	· · · · · · · · · · · · · · · · · · ·
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	
Collection Date			
Immunologic Tests (CD4 count and percent	age)		
CD4 count cells/µL CD4 percen	tage%	Collection Date	<i></i>
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	
Documentation of Tests			
Complete only if none of the following were positive DNA), HIV-1/2 type-differentiating immunoassay (sup	for <b>HIV-1</b> : Western blot, plemental test), stand-a	, IFA, culture, quantitativalone p24 antigen, or nu	ve NAAT (RNA or DNA), qualitative NAAT (RNA or icleotide sequence.
Did documented laboratory test results meet app	proved HIV diagnostic	algorithm criteria?	Yes No Unknown
If YES, provide specimen collection date of earlie	est positive test result	for this algorithm	
Is earliest evidence of HIV infection diagnosis do If YES, provide date of diagnosis by physician	cumented by a physic	ian rather than by lab	pratory test results? Yes No Unknown
Date of last documented negative HIV test result	(before HIV diagnosis of	date) / /	
Specify type of test:	,	,	
Testing Option (if applicable)			
Point-of-care test by provider Self-tes	t, result directly observ	ed by a provider <sup>2</sup>	Lab test, self-collected sample
<sup>2</sup> Results not directly observed by a provider should be recoverall interpretation. Complete the analyte results when an arrangement of the control of t	orded in HIV Testing Histor vailable.	y. <sup>3</sup> Complete the overall in	terpretation and the analyte results. <sup>4</sup> Always complete the
X. Treatment/Services Referrals (reco	rd all dates as mm/dd	l/yyyy)	
Has this patient been informed of his/her HIV info	ection? This pati	ent's partners will be r	notified about their HIV exposure and counseled by
Yes No Unknown	1-Hea	lth dept 2-Physic	ian/Provider 3-Patient 9-Unknown
Evidence of receipt of HIV medical care other that (select one; record additional evidence in Comment	-	ilt	, ,
1-Yes, documented 2-Yes, client self-r	•	Date of medica	al visit or prescription
For Female Patient			
This patient is receiving or has been referred	Is this patient curre	ently pregnant?	Has this patient delivered live-born infants?
for gynecological or obstetrical services	Yes		Yes
Yes No	No Unknown		No Unknown
Unknown	CHRIDWII		Onkilowii

For Children	of Patient (record most recer	nt birth in these boxes; record	additional or mu	ıltiple births in Co	omments)	
*Child's Name	9	Child's Date of Birth	Child's Last N	lame Soundex	Child's S	tate Number
Facility Name	of Birth (if child was born at hor	me, enter "home birth")				*Phone
Facility Type Inpatient: Hospital	Other, specify	Outpatient: Other, specify	E	er Facility: Emergency room Corrections	Unknow Other, ទរុ	
*Street Addre	ess			City		
County		State/Country				*ZIP Code
XI. Antire	troviral Use History (rec	ord all dates as mm/dd/yyyy)				
Main source	of antiretroviral (ARV) use infor	mation (select one) Date p	patient reported	information	Ever taken a	ny ARVs?
Patient inte Medical re	erview Provider repor cord review NHM&E	rt Other	//_		Yes	No Unknown
If yes, reason	for ARV use (select all that appl	ly)				
	ARV medications	•		Date began	1	Date of last use
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				/	<i>J</i>	/
Other (spe	cify reason)					
	ARV medications			Date began	/	Date of last use
XII. HIV Te	esting History (record all d	ates as mm/dd/yyyy)				
Main source Patient inte	of testing history information (serview Medical record review	•	NHM&E	Other	Date patient	reported information
Ever had prev	vious positive HIV test result?  No Unknown	Date of first positive HIV tes	st result			positive test result from erformed by the patient?
			1			
Ever had a ne	egative HIV test result? No Unknown	Date of last negative HIV tes (if date is from a lab test with t type, enter in Lab Data section	est			negative test result from erformed by the patient? No Unknown
		ι, μο, οποι πι <u>Δαο Δαια σσοπο</u> ι	7			
	egative HIV test results within the three regative test results we	-		ılt	Unknown Unknown	
XIII. Comr			, and passers			
Aiii. Goiiii	1101110					
XIV. *Loca	II/Optional Fields					