INSTRUCTIONS FOR COMPLETION OF THE GEORGIA ADULT HIV/AIDS CASE REPORT FORM

The Adult HIV Confidential Case Report Form, (CDC 50.42A/CDC 50.42C), replaces all prior versions and is used to report individuals 13 years of age and older with HIV or AIDS. Instructions for section of the form are described below. The form should be completed by a health care provider including doctors, physician assistants, nurses, case managers, or a designated representative with proper training. The form should NOT be completed by the patient. This form may be downloaded from http://health.state.ga.us/epi/hivaids. Hard copies of the form can be obtained by calling 1-800-827-9769.

The case report form is designed to confidentially collect information that will assist in characterizing HIV/AIDS in Georgia. Accurate, thorough case reports provide important information regarding the transmission of HIV. Reporting an individual's sex, date of birth, race, ethnicity, and behavior allows public health to develop and evaluate prevention and care programs targeted to specific at-risk populations and indentify areas of need. No identifying information from this case report form is transmitted to the Centers for Disease Control and Prevention.

Providers should report all patients with evidence of HIV infection, including AIDS, within 7 days diagnosis. Additionally, providers should report all new patients with HIV/AIDS for whom they are assuming care. The form can also be used to update a patient's clinical classification from HIV to and his/her vital status. AIDS cases include all patients with laboratory confirmation of HIV infection who also have a documented low CD4 level (<200 cells/ul or <14% of total lymphocytes) and/or the AIDS indicator diseases listed in Section IX, Laboratory data, of the report form.

All HIV-infected pregnant women should be reported immediately using this form. All babies born HIV-infected mothers should be reported immediately after birth using the Pediatric HIV/AIDS Case Report Form which can be found on the following website. http://health.state.ga.us/epi/hivaids

Please send completed reports in a double envelope marked "*Confidential" and "To be Opened by Addressee Only"* to:

Georgia Division of Public Health

Epi Section

P.O. Box 2107

Atlanta, GA 30301

Phone: 1-800-827-9769

http://health.state.ga.us/epi/hivaids

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Instructions for Completing Each Section

Definition of variable designators

- **Required**: Variables that must be collected by all sites.
- **Recommended**: Variables that sites are strongly encouraged to collect but are not absolutely required.
- **Optional**: Variables that may or may not be collected.

1. Patient Identification

Patient Identification

*Patient Name *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 ☐ Postal ☐ Shelter ☐ Temporary	*Current Street Address		*Phone ( ) _____	
City	County	State/Country	*ZIP Code	
*Medical Record Number	*Other ID Type:	Number:		

*Information NOT transmitted to CDC

Patient identifier information is for state/local health department use only and is not transmitted to CDC. Enter the data below for all persons being reported with HIV.

1.1 PATIENT NAME (**Required**, applies to Health Dept & Health Care Providers)

- Enter patient's first name, middle name, and last name.

1.2 LAST NAME SOUNDEX (**Required**, applies to Health Dept & Health Care Providers)

- After patient name is entered into CDC-supplied software, the software generates this variable by using the patient's last name. After the code is automatically generated, health department staff should fill this field on the form.
- This variable is a phonetic, alphanumeric code calculated by converting a surname into an index letter and a three-digit code. The index letter is the first letter of the surname. The eHARS Technical Reference Guide describes exactly how the Last Name Soundex is created.

1.3 ALTERNATE NAME TYPE (**Optional**)

- If available, write in the alternate name type (such as Alias, Married) and patient's alternative first name, middle name, and last name.

1.4 ADDRESS TYPE (**Required**, applies to Health Dept & Health Care Providers)

- Select one of the address types (residential, bad address, correctional facility, foster home, homeless, postal, shelter, or temporary) for the patient's current address.

1.5 CURRENT STREET ADDRESS (**Required**, applies to Health Dept & Health Care Providers)

- Enter the patient's current street address.

1.6 PHONE (**Required** if patient has a telephone, applies to Health Dept & Health Care Providers)

- Enter patient's current home area code and telephone number.

1.7 CITY (each element **Required**, applies to Health Dept & Health Care Providers)

- Enter patient's current city

1.8 COUNTY (each element **Required**, applies to Health Dept & Health Care Providers)

- Enter patient's current county

1.9 STATE/COUNTRY (each element **Required**, applies to Health Dept & Health Care Providers)

- Enter patient's current state/country

1.10 ZIP CODE COUNTY (each element **Required**, applies to Health Dept & Health Care Providers)

- Enter patient's current zip code

1.11 MEDICAL RECORD NUMBER

- Enter medical record number of the patient if available.

1.12–1.13 OTHER ID TYPE AND NUMBER

- Enter any additional patient's ID type (such as social security number)

2. Health Department Use Only

Health Department Use Only

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	

2.1 DATE RECEIVED AT HEALTH DEPARTMENT (**Optional**)

- Enter date in *mmddyyyy* format.

2.2 eHARS DOCUMENT UID

- Enter UID after CDC-supplied software generates this variable.

2.3 STATE NUMBER (**Required**)

- Enter the assigned state patient number.
- Each patient should have a unique state number throughout the course of HIV disease in each state/jurisdiction where they are reported.
- Assigned numbers **should not** be reused, even if the case is later deleted.
- This variable is used, along with the state of report, to uniquely identify cases reported to CDC and to merge the state datasets without duplication.

2.4 REPORTING HEALTH DEPARTMENT -CITY/COUNTY

- Enter name of city and county of the health department that receives the report from providers of surveillance data.

2.5 CITY/COUNTY NUMBER

- Enter the assigned city/county patient number.
- Each patient should have a unique city/county number throughout the course of HIV disease assigned by the separately funded city in which they are reported.

- Assigned numbers **should not** be reused, even if the case is later deleted.

2.6 DOCUMENT SOURCE (**Required**, applies to Health Dept)

- Enter the code for the document source that provided the information for this report (formerly report source).
- To clearly identify multiple data sources for a given HIV case (all stages), use a separate case report form for each source.
- If coding proves difficult, write in document source for later coding.

2.7 SURVEILLANCE METHOD (**Required**)

- Enter the method the case report was ascertained- active, passive, follow up, reabstraction or unknown.

2.8 DID THIS REPORT INITIATE A NEW INVESTIGATION? (**Optional**)

- Enter whether this case report initiated a new investigation by the health department- yes, no or unknown.

2.9 REPORT MEDIUM (**Optional**)

- Health department staff review medical records at provider sites or receive information over the telephone, by fax, e-mail, US mail, etc. to establish an HIV case and to elicit information for HIV case report forms. The health department can also receive HIV case reports from physicians, laboratories, or other individuals or institutions through electronic transfer or CD/disks. Enter the medium in which the case report was submitted. Choose one of the following options: Field visit, mail, fax, phone, electronic transfer or CD/Disk.

3. Facility Providing Information

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 ( ) _____

3.1 FACILITY NAME (**Optional**, applies to Health Dept & Health Care Providers)

- Enter name of the facility providing the information.
- If HIV, stage 1-2 or 3(AIDS) were reported from different facilities, enter name of each on separate forms, specifying which occurred at which facility.

3.2 PHONE (**Optional**, applies to Health Dept & Health Care Providers)

- Enter facility's current area code and telephone number.

3.3 STREET ADDRESS (**Optional**, applies to Health Dept & Health Care Providers)

- Enter facility's street address.

3.4 CITY (**Optional** applies to Health Dept & Health Care Providers)

- Enter city where facility providing information is located.

3.5 COUNTY (**Optional** applies to Health Dept & Health Care Providers)

- Enter county where facility providing information is located.

3.6 STATE/COUNTRY (**Optional**, applies to Health Dept & Health Care Providers)

- Enter state, country name where facility providing information is located.

3.7 ZIP CODE (**Optional**, applies to Health Dept & Health Care Providers)

- Enter ZIP code where facility providing information is located.

3.8 FACILITY TYPE (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response corresponding to the type of facility providing information

3.9 DATE FORM COMPLETED (**Required**, applies to Health Dept & Health Care Providers)

- Enter date in *mmddyyyy* format.

3.10 PERSON COMPLETING FORM (**Optional**, applies to Health Dept & Health Care Providers)

- Enter the name of the person completing the form who can be contacted to clarify entries and supply additional information.

3.11 PHONE (**Optional**, applies to Health Dept & Health Care Providers)

- Enter the telephone number of the person completing the form.

4. PATIENT DEMOGRAPHICS

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/Pacific Islander ☐ White ☐ Unknown		***Expanded Race** _____

4.1 SEX ASSIGNED AT BIRTH (**Required**, applies to Health Dept & Health Care Providers)

- Select patient's sex assigned at birth.

4.2 COUNTRY OF BIRTH (**Optional**, applies to Health Dept & Health Care Providers)

- Select applicable response from boxes provided.

4.3 DATE OF BIRTH (**Required**, applies to Health Dept & Health Care Providers)

- Enter patient's month, day, and year of birth.
- Enter date in *mmddyyyy* format.

4.4 ALIAS DATE OF BIRTH (**Optional**, applies to Health Dept & Health Care Providers)

- If available, write in the Alias date of birth.
- Enter date in *mmddyyyy* format.

4.5 VITAL STATUS (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.

4.6 DATE OF DEATH (**Required** if applicable, applies to Health Dept & Health Care Providers)

- If patient is deceased, enter date of death.
- Enter date in *mmddyyyy* format.

4.7 STATE OF DEATH (**Optional** if applicable, applies to Health Dept & Health Care Providers)
- If patient is deceased, enter the state/territory where death occurred.

4.8 CURRENT GENDER IDENTITY (**Optional** if applicable, applies to Health Dept & Health Care Providers)
- Enter the current gender identity of the patient, even if it is the same as the sex assigned at birth male, female, transgender male-to-female, transgender female-to-male, unknown, or additional gender identity.
- If the person's stated gender identity differs from ~~of~~ the selections provided, please check the additional gender identity box and specify in the blank.

4.9 ETHNICITY (**Required**, applies to Health Dept & Health Care Providers)
- Select applicable response.
- If no ethnicity information is available, select "Unknown".
- Do not choose unknown unless search for this datum was unsuccessful.

4.10 EXPANDED ETHNICITY (**Optional,** if applicable, applies to Health Dept & Health Care Providers)
- Enter more specific ethnicity information for greater detail such as "Hispanic or Latino, Cuban or Hispanic or Latino. Puerto Rican".
- Refer to the eHARS Technical Reference Guide for listing of expanded ethnicity.

4.11 RACE (**Required**, applies to Health Dept & Health Care Providers)
- Select patient's race even if information was submitted for ethnicity.
- Select more than one race if applicable.
- If no race information is available, select "Unknown".

4.12 EXPANDED RACE (**Optional,** if applicable, applies to Health Dept & Health Care Providers)
- Enter more specific race information for greater detail such as "American Indian or Alaska Native.Navajo" or "White. Middle Eastern or North Africa.Egyptian".

5. RESIDENCE AT DIAGNOSIS

Residence at Diagnosis (add additional addresses in Comments)

Address Type (Check all that apply to address below) □ Residence at HIV diagnosis □ Residence at AIDS diagnosis □ Check if SAME as Current Address			
*Street Address			
City	County	State/Country	*ZIP Code

5.1 ADDRESS TYPE (**Required**, applies to Health Dept & Health Care Providers)
- Select one the address type (residence at HIV diagnosis, residence at AIDS diagnosis, check if same as current address) for the patient's residence at diagnosis being reported on the case report form
- If the patient's residence at HIV diagnosis and AIDS diagnosis was the same, you may check both.

5.2 STREET ADDRESS (**Required**, applies to Health Dept & Health Care Providers)

- Enter residence's street address at diagnosis.

5.3 CITY (**Required**, applies to Health Dept & Health Care Providers)
- Enter city of patient's residence at diagnosis.

5.4 COUNTY (**Required**, applies to Health Dept & Health Care Providers)
- Enter county of patient's residence at diagnosis.

5.5 STATE/COUNTRY (**Required**, applies to Health Dept & Health Care Providers)
- Enter the state/country of patient's residence at diagnosis.

5.4 ZIP CODE (**Required**, applies to Health Dept & Health Care Providers)
- Enter the ZIP code of patient's residence at diagnosis.

6. STATE/LOCAL USE ONLY

Diagnosing physician or healthcare provider identifier information is supplied in this section.

STATE/LOCAL USE ONLY	– Patient identifier information is not transmitted to CDC! –
Physician's Name: (Last, First, M.I.) _____ Phone No: ( ) _____	Medical Record No._____
Hospital/Facility: _____	Person Completing Form: _____ Phone No: ( ) _____

6.1 PHYSICIAN'S NAME (**Optional**)
- Enter name of physician who diagnosed patient (last, first, M.I.).
- Enter name of physician medically managing patient.

6.2 PHONE NO. (**Optional**)
- Enter phone number of physician named at 6.1, above.
- If no physician is named, enter phone number of the facility of diagnosis.

6.3 MEDICAL RECORD NO.
- Enter medical record number of the patient if available that is being used by the physician or healthcare provider who diagnosed the patient (if different).

6.4 HOSPITAL/FACILITY (**Optional**)
- Enter the name of the facility where the report originated.
- If this report is generated from a laboratory report of HIV infection, the laboratory slip should contain the name of the facility where the specimen was collected.

6.5 PERSON COMPLETING FORM (**Optional**, applies to Health Dept & Health Care Providers)
- Enter the name of the person completing the form who can be contacted to clarify entries and supply additional information.

6.6 PHONE NO. (**Optional**, applies to Health Dept & Health Care Providers)
- Enter the telephone number of the person completing the form.

7. FACILITY OF DIAGNOSIS

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type ☐ HIV ☐ AIDS (check all that apply to facility below) ☐ 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**	

7.1 DIAGNOSIS TYPE

- Enter the diagnosis type that corresponds to the facility of diagnosis being reported.

7.2 FACILITY NAME (**Optional**, applies to Health Dept & Health Care Providers)

- Enter name of the facility where patient was first diagnosed with diagnosis type being reported.
- If HIV, stage 1-2, unknown and stage 3 (AIDS) diagnoses occurred at different facilities, enter name of each on separate forms, specifying which diagnosis occurred at which facility.

7.3 PHONE (**Optional**, applies to Health Dept & Health Care Providers)

- Enter facility's current area code and telephone number.

7.4 STREET ADDRESS (**Optional**, applies to Health Dept & Health Care Providers)

- Enter facility's street address.

7.5 CITY (**Optional**, applies to Health Dept & Health Care Providers)

- Enter city where facility of diagnosis is located.

7.6 COUNTY (**Optional**, applies to Health Dept & Health Care Providers)

- Enter county where facility of diagnosis is located.

7.7 STATE/COUNTRY (**Optional**, applies to Health Dept & Health Care Providers)

- Enter state, country name where facility of diagnosis is located.

7.8 ZIP CODE (**Optional**, applies to Health Dept & Health Care Providers)

- Enter ZIP code where facility of diagnosis is located.

7.9 FACILITY TYPE (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response corresponding to the type of facility where patient received diagnosis of HIV.

7.10 PROVIDER NAME (**Optional**)

- Enter provider's name where patient first received a diagnosis of HIV, stage 1-2 or stage 3 (AIDS).

7.11 PROVIDER PHONE (**Optional**)

- Enter provider's current area code and telephone number.

7.12 SPECIALTY

- Enter provider's specialty.

8. PATIENT HISTORY

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 non-prescription drugs	□ Yes □ No □ Unknown
Received clotting factor for hemophilia/ coagulation disorder — Specify clotting factor: Date received (mm/dd/yyyy):__ __ /__ __ /__ __ __ __	□ 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 AIDS or documented HIV Infection, risk not specified	□ Yes □ No □ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section) First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __	□ Yes □ No □ Unknown
Received transplant of tissue/organs or artificial insemination	□ Yes □ No □ Unknown
Worked in a healthcare or clinical laboratory setting If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	□ Yes □ No □ Unknown
Other documented risk (please include detail in Comments section)	□ Yes □ No □ Unknown

<u>These data yield information about how patients may have acquired their infections.</u>

- Respond to each risk factor, selecting "Yes" for all factors that apply; "No" for those that do not apply, i.e., only select "No" if medical record specifically states this is not a risk factor; and "Unknown" for those for which investigation failed to yield an answer. If an investigation for a particular item was not performed, then you should leave it blank.
- Mark if the risk factor was a pediatric risk on the top of this section and enter additional information in the COMMENTS section.

8.1 SEX WITH MALE (**Required**, applies to Health Dept & Health Care Providers)

- Some <u>examples</u> of information from the medical record which would strongly indicate sex with a male are
  - For male patient
    - Married to or divorced from a male
    - Rectal gonorrhea
  - For female patient
    - Married to or divorced from a male
    - Boyfriend referenced in the medical record
    - Living with a male "partner"
    - History of pregnancy
    - History of another sexually transmitted infection (in addition to HIV)
    - Sex worker (either current or in the past)

8.2 SEX WITH FEMALE (**Required**, applies to Health Dept & Health Care Providers)

- Some examples of information from the medical record which would strongly indicate sex with a female are
  - For male patient
    - Married to or divorced from a female

  Has a biological child
  - For female patient
    - Married to or divorced from a female

8.3 INJECTED NON-PRESCRIPTION DRUGS (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response (i.e. heroin, methamphetamines, cocaine).

8.4 RECEIVED CLOTTING FACTOR FOR HEMOPHILIA/COAGULATION DISORDER (**Required**, applies to Health Dept & Health Care Providers)

- "Coagulation disorder" or "hemophilia" refers only to a disorder of a clotting factor; factors are any of the circulating proteins named Factor I through Factor XII. These disorders include Hemophilia A and Von Willebrand's disease (Factor VIII disorders) and Hemophilia B (a Factor IX disorder).

- Select applicable response.
- This risk factor is generally documented in the history and physical section of the patient's medical chart.
  - If "Yes" specify the clotting factor and enter date received. Enter date in *mmddyyyy* format.
  - They do not include other bleeding disorders, such as thrombocytopenia, treatable by platelet transfusion.
  - If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select "No."

8.5 HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING: This section, addressed at 8.5.1–8.5.6, relates to ascertainment of risk among heterosexual sex partners of the case patient.

8.5.1 INTRAVENOUS/INJECTION DRUG USER (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.

8.5.2 BISEXUAL MALE (**Required**, applies to Health Dept & Health Care Providers)

- Applies only to **female** cases.
- Select applicable response.

8.5.3 PERSON WITH HEMOPHILIA/COAGULATION DISORDER WITH DOCUMENTED HIV INFECTION (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- "Coagulation disorder" or "hemophilia" refers only to a disorder of a clotting factor. They do not include other bleeding disorders, such as thrombocytopenia, treatable by platelet transfusion. If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select "No."

8.5.4–8.5.5 TRANSFUSION RECIPIENT WITH DOCUMENTED HIV INFECTION—

TRANSPLANT RECIPIENT WITH DOCUMENTED HIV INFECTION (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- Consider documenting the reason for transfusion/transplant in the Comments section.

8.5.6 PERSON WITH AIDS OR DOCUMENTED HIV INFECTION, RISK NOT SPECIFIED (**Required**, applies to Health Dept & Health Care Providers)

- Select "Yes" only if HETEROSEXUAL sex partner is known to be HIV positive and that partner's risk factor for HIV is unknown.

8.6 RECEIVED TRANSFUSION OF BLOOD/BLOOD COMPONENTS (OTHER THAN CLOTTING FACTOR) (**Required**, applies to Health Dept & Health Care Providers)

- 'Blood,' according to http://cancerweb.ncl.ac.uk/cgi-bin/omd?blood, is defined as a circulating tissue composed of a fluid portion (plasma) with suspended formed elements (red blood cells, white blood cells, platelets).
- 'Blood components' that can be transfused, according to http://cancerweb.ncl.ac.uk/cgi-bin/omd?blood, include erythrocytes, leukocytes, platelets, and plasma.
- If "Yes," specify month, day, and year of first and last transfusions before occurrence of patient's HIV diagnosis.
- It is often helpful to document the reason for the transfusion in the Comments section.

8.7 RECEIVED TRANSPLANT OF TISSUE/ORGANS OR ARTIFICIAL INSEMINATION (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- Alert the state/local cases of public health importance (COPHI) coordinator.

8.8 WORKED IN HEALTH CARE OR CLINICAL LABORATORY SETTING (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- If "Yes," specify occupation and setting.
- Investigate apparent occupational exposures to determine if this was the only risk factor present.

9. LABORATORY DATA

Laboratory Data (record additional tests in Comments section)

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 **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 **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:** __ __ /__ __ /__ __ __ __
HIV Detection Tests (Qualitative)
TEST 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __
TEST 2: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture
RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __
HIV Detection Tests (Quantitative viral load) Note: Include earliest test after diagnosis
TEST 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)
RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __
TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)
RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __
Immunologic Tests (CD4 count and percentage)
CD4 at or closest to current diagnostic 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:** __ __ /__ __ /__ __ __ __
Documentation of Tests
Date of last documented negative HIV test: __ __ /__ __ /__ __ __ __   Specify type of test: _____   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: __ __ /__ __ /__ __ __ __

- "COLLECTION DATE" refers to the date when the specimen was collected or drawn.
- Enter dates in *mmddyyyy* format.
- If search for either or both of these data was unsuccessful, then enter ".." for unknown day, month or year of "COLLECTION DATE."
- Record all laboratory tests.
- Include all diagnostic and CD4 tests where possible. Where number of tests exceeds the number of fields available on the form, record such results in the Comments section.
- In the absence of lab tests, record HIV, stage 1-2 or stage 3 (AIDS) diagnostic evidence documented in the chart by a physician.

9.1 HIV ANTIBODY TESTS (NON_TYPE DIFFERENTIATING)

- Assuming active case finding, review patient's chart and lab reports for the earliest date of documented HIV positivity, "Indeterminate" refers to Indeterminate HIV antibody test results.
- Enter results and collection dates for first positive HIV antibody tests.

- The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate
- Check the Rapid Test box if the test is rapid.
- Enter date in *mmddyyyy* format.

9.1.1 HIV-1 EIA (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter result and collection date of first HIV-1 EIA.
- "Positive EIA" means repeatedly reactive tests on a single sample.
- Enter date in *mmddyyyy* format.

9.1.2 HIV-1/2 COMBINATION EIA (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter result and collection date of first HIV-1/ 2 combination EIA test.
- If tests indicate HIV-1 or HIV-2 results separately, please specify the results as given in the laboratory report.
- Enter date in *mmddyyyy* format.

9.1.3 HIV-1/2AgAb
- Enter results and collection date of combined p24 antigen and anti HIV1/2 antibody screening assay.
- Enter date in *mmddyyyy* format.

9.1.4 HIV-1 WESTERN BLOT (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter the result and collection date of first HIV-1 Western blot.
- Enter date in *mmddyyyy* format.

9.1.5 HIV-1 IFA (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter the result and collection date of first HIV-1 IFA.
- Enter date in *mmddyyyy* format.

9.1.6 HIV-2 EIA (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter result and date of first HIV-2 EIA.
- "Positive EIA" means repeatedly reactive tests on a single sample.
- Enter date in *mmddyyyy* format.

9.1.7 HIV-2 WESTERN BLOT (each element **Required**, applies to Health Dept & Health Care Providers)
- Enter the result and collection date of first HIV-2 Western blot. Enter date in *mmddyyyy* format.
- If HIV-1 tests other than those at 9.1.1–9.1.5 were employed, specify the type of test performed.
- Enter the result and collection date.
- Enter date in *mmddyyyy* format.

9.2 HIV ANTIBODY TESTS (TYPE DIFFERENTIATING)
- Assuming active case finding, review patient's chart and lab reports for the earliest date of

documented HIV positivity.

- Enter results and collection dates for first positive HIV antibody tests. The possible results are: HIV-1, HIV-2, Both (undifferentiated), or Neither (negative).
- Enter date in *mmddyyyy* format.

9.3 HIV DETECTION TESTS (QUALITATIVE) (**Required**, applies to Health Dept & Health Care Providers)

- These are all qualitative tests. All varieties of such tests establish the presence of the pathogen, HIV. By contrast, HIV tests such as the EIA or Western blot establish the presence of our immune systems' response to the pathogen—HIV antibodies.
- Select applicable response corresponding to earliest positive detection test.
- The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate.

9.3.1 HIV-1 RNA/DNA NAAT (QUAL)

9.3.2 HIV-1 P24 ANTIGEN (**Required**, applies to Health Dept & Health Care Providers)

- Antigens are the virus's own proteins; such tests are specific for these proteins.
- Enter result and collection date of earliest antigen test.
- Enter date in *mmddyyyy* format.

9.3.3 HIV-1 CULTURE (**Required**, applies to Health Dept & Health Care Providers)

- Enter result and collection date of earliest test by culture.
- Enter date in *mmddyyyy* format.

9.3.4 HIV-2 RNA/DNA NAAT (QUAL)

9.3.5 HIV-2 CULTURE (**Required**, applies to Health Dept & Health Care Providers)

- Enter result and collection date of earliest test by culture.
- Enter date in *mmddyyyy* format.

9.4 HIV DETECTION TESTS (QUANTITATIVE VIRAL LOAD)

- 9.4.1 HIV-1 RNA/DNA NAAT (QUANTITATIVE VL)
    - The possible results are: Detectable or Undetectable
    - Enter results in units of copies per milliliter (mL) and Log. Enter the month, day, and year test was collected. Viral load tests with undetectable results should also be entered here.
    - COPIES/ML (each element **Required**, applies to Health Dept & Health Care Providers) Enter result in units of viral copies per milliliter. Where detectable results are reported with log data only, enter "greater than detection limits for this assay" under the copies/mL field. Because undetectable results are typically reported as below the detection limits of the assay rather than by a specific quantitative value, enter "fewer than detectable by this assay" under the copies/mL field

9.5 IMMUNOLOGIC TESTS (CD4 COUNT AND PERCENTAGE)

- Whenever CD4 count and percentage are both available, record both. Enter specimen collection date to the reported CD4 test result

9.5.1 CD4 AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

9.5.1.1 CD4 COUNT (**Required**, applies to Health Dept & Health Care Providers)

- For HIV reports, record the CD4 count closest to the time patient was determined to be HIV infected. If this information is not available when the initial case report is completed, it may be entered later. For HIV, stage 3 (AIDS) reports, record the CD4 count with date at or closest to the date of AIDS diagnosis. This AIDS diagnosis date is typically the date on which an AIDS-defining illness is diagnosed or the specimen collection date of a CD4 count < 200 cells/µL.

9.5.1.2 CD4 PERCENTAGE (**Required**, applies to Health Dept & Health Care Providers)

- For HIV reports, record the CD4 percentage with date at or closest to the date of HIV diagnosis. For stage 3 (AIDS) reports, record the CD4 percentage at or closest to the time that an AIDS-defining clinical condition was first diagnosed. This AIDS diagnosis date is typically the date on which an AIDS-defining illness is diagnosed or the specimen collection date of a CD4 count < 200 cells/µL.

9.5.2 FIRST CD4 RESULT < 200 cells/µL or < 14%

9.5.2.1 CD4 COUNT (**Required** if available, applies to Health Dept & Health Care Providers)

- Enter results and specimen collection date of first CD4 < 200 cells/µL.
- Enter date in *mmddyyyy* format.

9.5.2.2 CD4 PERCENTAGE (**Required** if available, applies to Health Dept & Health Care Providers)

- Record results and specimen collection date of first CD4 <14%.
- Enter date in *mmddyyyy* format.

9.6 DOCUMENTATION OF TESTS

9.6.1 DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (SPECIFY TYPE)

- Enter type of test and specimen collection date. A negative HIV test result does not necessarily represent absence of infection. Because antibody tests such as the HIV-ELISA are the standard means of screening for HIV infection, the test type specified in this field is typically an antibody test. Additionally, HIV-2 infection would be missed by assays specific to detection of HIV-1 antibodies; such case reports could include a previous HIV-1 negative antibody test result here. By contrast, other HIV tests, such as those measuring viral load, are typically ordered for patients already known to be infected; so these are not included here. Patient self report of last negative test is not considered "documented" and thus should not be entered in this field.
- Enter date in *mmddyyyy* format.

9.7 IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY A PHYSICIAN? (**Required** if applicable, applies to Health Dept & Health Care Providers)

- Select applicable response. If laboratory evidence of an HIV test is unavailable in the patient's medical or other record and written documentation of lab evidence of HIV infection consistent with the HIV case definition is noted by the physician, enter "Yes"; otherwise enter "No" or "Unknown."

9.7.1 IF "YES" TO 9.7, PROVIDE DATE OF DOCUMENTATION BY PHYSICIAN (**Required** in the absence of lab results, applies to Health Dept & Health Care Providers)

- If antibody tests are not available in chart, enter date of the note in which the physician documents the patient's HIV infection. Do not record earlier date stated by the patient or the date that the physician says in the note. For example, if a health care provider writes a note in a medical chart on 4/10/2010 stating the patient had positive HIV EIA and WB the previous

month. You would record 4/10/2010 as the date of documentation by the physician.

- Enter date in *mmddyyyy* format.

10. CLINICAL

Clinical (select D for Definitive or P for Presumptive where applicable) (record all dates as mm/dd/yyyy)

	D	P	Date		D	P	Date		D	P	Date
Candidiasis, bronchi, trachea, or lungs				Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				M. tuberculosis, pulmonary†			
Candidiasis, esophageal				Histoplasmosis, disseminated or extrapulmonary				M. tuberculosis, disseminated or extrapulmonary†			
Carcinoma, invasive cervical				Isosporiasis, chronic intestinal (>1 mo. duration)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
Coccidiodomycosis, 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			

†If TB selected above, indicate RVCT Case Number:

10.1 CLINICAL

10.1.1–10.1.26 (**Optional,** applies to Health Dept & Health Care Providers)

- Select all that apply and enter diagnosis dates. Enter date in *mmddyyyy* format.
- Definitive diagnoses are based on specific laboratory methods such as histology or culture.
- Presumptive diagnoses of AIDS-defining conditions (e.g. opportunistic infections) are diagnoses made by any method other than the definitive methods listed in the case definition.

10.1.27 RVCT CASE NUMBER

- If this patient has a verified case of tuberculosis (TB), health department staff enter the nine-digit alphanumeric code from the TB case report or TB data management system. Providers in the private and public sectors diagnosing tuberculosis in their AIDS patients may get this number from TB surveillance staff.

11. TREATMENT/SERVICES REFERRALS

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		
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 the Comments section)			
*Child's Name	Child Soundex	Child's Date of Birth	
*Child's Coded ID	Child's State Number		
Hospital of Birth (if child was born at home, enter "home birth" for hospital name)			
Hospital Name	*Phone	*Zip Code	
*Street Address	City	County	State/Country

11.1 HAS THIS PATIENT BEEN INFORMED OF HIS/HER HIV INFECTION? (**Optional**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- If notification is not documented, select "Unknown" unless the person completing the form knows with certainty that the patient is aware of the infection.

11.2 THIS PATIENT'S PARTNERS WILL BE NOTIFIED ABOUT THEIR HIV EXPOSURE AND COUNSELED BY (**Optional**, applies to Health Dept & Health Care Providers)

- Select applicable response.

11.3 FOR FEMALE PATIENT

11.3.1 THIS PATIENT IS RECEIVING OR HAS BEEN REFERRED FOR GYNECOLOGICAL OR OBSTETRICAL SERVICES (**Optional**, applies to Health Dept & Health Care Providers)

- Select applicable response.

11.3.2 IS THIS PATIENT CURRENTLY PREGNANT? (**Required**, applies to Health Dept & Health Care Providers)

- Select applicable response. Response is dependent on which date was selected for populating the field described for Date form completed. If patient was pregnant on that date, select "Yes."

11.3.3 HAS THIS PATIENT DELIVERED LIVE-BORN INFANTS? (**Optional**, applies to Health Dept & Health Care Providers)

- Select applicable response.
- If "Yes", provide birth information for the most recent birth as described at 11.4 below.
- Information on additional or multiple births can be recorded in Comments.

11.4 FOR CHILDREN OF PATIENT

11.4.1 CHILD'S NAME

- Enter name of child.

11.4.2 CHILD'S SOUNDEX

- To be completed by state/local health department personnel.
- Retrieve soundex from the HIV registry (database) and enter here if child's name was previously entered in your database and a Stateno exists.

- If child's name has not been entered yet, enter name and date of birth information in the CDC-provided software. This software will convert child's surname to a soundex code. Enter date in *mmddyyyy* format.

11.4.3 CHILD'S DATE OF BIRTH

- Enter child's month, day, and year of birth. Enter date in *mmddyyyy* format.
- Child to whom field refers is from the most recent birth.

11.4.4 CHILD'S CODED ID

- Enter any additional patient's ID type (such as social security number) and the number of the other ID.

11.4.5 CHILD'S STATE PATIENT NUMBER.

- To be completed by state/local health department personnel.
- This number is typically assigned by state/local health department personnel if the child is known to have received a diagnosis of HIV (all stages). Some states also assign numbers for children classified as "Perinatally HIV Exposed" or "Seroreverter."

11.5 HOSPITAL OF BIRTH

- Enter the name, street address, phone number, city, county, and state of the hospital where the child described at 11.4 above was born.
- If the child was born at home, enter "home birth."

12. HIV Testing and Antiretroviral Use History Section

HIV Testing and Antiretroviral Use History (if required by Health Department) (record all dates as mm/dd/yyyy)

Main source of testing and treatment history information (select one) □ Patient Interview □ Medical Record Review □ Provider Report □ NHM&E/PEMS □ Other	Date patient reported information __ __/__ __/__ __ __ __
Ever had previous 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 Lab 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, ARV medications:
Dates ARVs taken Date first began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __

The HIV testing and antiretroviral use history section is required for the use of state and local health departments that conduct HIV Incidence Surveillance (HIS). The medication use questions are also required for areas conducting Variant, Atypical and Resistant HIV Surveillance (VARHS). This section is optional for all other surveillance areas. These testing and treatment history (TTH) data are used along with the serologic testing algorithm for recent HIV seroconversion (STARHS) results to generate national, state and local HIV incidence estimates. Unlike other sections on the ACRF, patient self-reported information is accepted for all answers. For detailed instructions, consult the Guidance for Collection and Data Entry of HIV Incidence Surveillance Information.

12.1 MAIN SOURCE OF TESTING AND TREATMENT (TTH) INFORMATION

- Check only one source, the main source from which the information in this section was obtained.
- 'Patient Interview' is selected only if the patient was directly asked a series of questions from this or another structured TTH form. Interviewer should have been trained on the proper collection of

TTH data.

- 'Provider Report' indicates this form is filled out by a health care provider.
- 'Medical Record Review' indicates that this information was obtained through abstraction of medical charts, electronic medical records or databases. Information may also come from a database of HIV test results or pharmacy records.
- 'NHM&E/PEMS' indicates that data were abstracted from the National HIV Monitoring and Evaluation (NHM&E) project forms or databases.
- 'Other' indicates that information came from a source other than those listed above.

12.2 DATE PATIENT REPORTED INFORMATION

- The appropriate date to enter depends on the MAIN SOURCE OF TTH INFORMATION:
- If there is a structured patient interview, enter the date of the interview. Enter date in *mmddyyyy* format.
- For a medical record review, enter the date of the last patient encounter that contributed to the TTH information collected. If only a lab report was accessed, enter the date of receipt of the lab results. If there was no patient encounter or lab test receipt date, then enter the date the medical record review was performed. Enter date in *mmddyyyy* format.
- If the ACRF is completed by a health care provider, enter the date of the last patient encounter when the most recent TTH information was obtained from the patient. If provider's information only came from another data source, such as a lab report, enter the date of receipt of the information. If there are no such dates, enter the date the ACRF was completed. Enter date in *mmddyyyy* format.

For information obtained through NHM&E/PEMS, use the date entered on the HIV Test Form.

- If there are no data available from the above sources, enter the date the ACRF was completed. Enter date in *mmddyyyy* format.

12.3 EVER HAD PREVIOUS POSITIVE HIV TEST?

- The purpose of this question is to report if any positive HIV test occurred before the known date of HIV diagnosis, for example a test performed in another state or country or an anonymous test. If there is a date of earlier positive HIV test, enter it in the next field on the form. Enter date in *mmddyyyy* format.
- Self-reported information is appropriate.
- Do not count indeterminate tests.
- 'Yes' indicates evidence that the person had a previous positive HIV test, including patient self-report.
- 'No' indicates sufficient evidence that there was no previous positive HIV test. Do not answer 'no' if there is a lack of evidence either way about previous tests.
- 'Refused' indicates patient refused to answer the question or facility refused to permit medical record review.
- 'Don't know' indicates that the patient, chart reviewer, or provider has no knowledge whether or not there was a previous positive HIV test, after searching for the information or asking the patient.

The field should be left blank if the medical record was not searched or the question was not asked

12.4 DATE OF FIRST POSITIVE HIV TEST

- Record the date of the earliest known positive HIV test, including patient self-reported dates. It is acceptable to enter an estimated or incomplete date, as long as it contains a year. Enter date in *mmddyyyy* format.
- If it is known that there were no previous positive HIV tests, enter the date of the first positive HIV test, i.e. the collection date of the diagnostic HIV test, and answer 'no' to the previous question ("Ever had previous positive HIV test"). Enter date in *mmddyyyy* format.
- If you do not know the date of HIV diagnosis, enter the earliest known positive HIV test.

12.5 EVER HAD A NEGATIVE HIV TEST?

- Because this question is used to classify persons as new or previous testers for incidence estimation, it is important to not make assumptions. The mere absence of information about previous tests in a medical record should not be recorded as 'no', since tests can occur in other venues.
- Self-reported information is accepted. Ignore indeterminate tests.
- 'Yes' indicates there is knowledge of a previous negative HIV test, either self-reported or confirmed by a laboratory report. If the answer is 'yes', enter the date in the next field on the form, if it is available. Enter date in *mmddyyyy* format.
- 'No' indicates there is evidence that the person never had a negative HIV test. For example, the person states they never have been tested before. Do not enter 'no' if there is simply no evidence either way about a previous HIV test.
- 'Refused' indicates patient refused to answer the question or facility refused to permit medical record review.
- 'Don't know/Unknown' indicates there is insufficient evidence supporting or denying the occurrence of a negative HIV test, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

12.6 DATE OF LAST NEGATIVE HIV TEST

- This is the most important information for incidence estimation. This date is used to categorize persons as repeat testers and to estimate frequency of testing.
- Self-reported information is accepted. Documented negative HIV test dates also should be entered in the Laboratory Data section under date of last documented negative HIV test, along with the test type.
- Enter the date of the last known negative HIV test, either self-reported or confirmed by a laboratory test. The person may have had a more recent negative test at another facility, unknown to the provider or chart abstractor, but it is more important to enter any known date than to leave it blank.
- Incomplete dates are acceptable if the year is included.
- Enter date in *mmddyyyy* format.

12.7 NUMBER OF NEGATIVE HIV TESTS WITHIN 24 MONTHS BEFORE FIRST POSITIVE TEST

- Count the number of negative HIV tests in the 24 months before the first positive HIV test. Do not count indeterminate or positive HIV tests or those with unknown results.
- Enter '0' if it is known that the patient has never been tested for HIV before or never had a negative test.
- Check 'Refused' if the patient refused to answer the question or facility refused to permit medical record review.
- Check 'Don't know/Unknown' if the patient or person completing the form does not know or if the results of a test are unknown, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

12.8 EVER TAKEN ANY ANTIRETROVIRALS (ARVS)?

- This field indicates whether the patient has ever taken any antiretroviral medication to prevent or treat HIV or hepatitis, particularly before HIV diagnosis. This is important because ARV use may affect STARHS results. Most patients have not taken ARVs before the date of HIV diagnosis, but some have taken them for hepatitis or for HIV pre-exposure prophylaxis (PrEP).
- This question is also used to determine specimen eligibility for the Variant, Atypical and Resistant HIV Surveillance (VARHS) system that monitors the distribution of HIV-1 mutations associated with HIV drug resistance and subtypes among persons with newly diagnosed HIV infection.
- 'Yes' indicates there is evidence that the person has taken ARVs, including self-report. If 'Yes', it is important to enter the dates when use began and, if appropriate, ended. Enter date in *mmddyyyy* format.
- 'No' indicates there is evidence that the patient has never taken ARVs.
- 'Refused' indicates that the patient refused to answer the question or facility refused to permit medical record review.
- 'Don't know/Unknown' should be used when the person completing the form does not know whether or not the patient has ever taken ARV's, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

12.9 IF YES, ARV MEDICATIONS

- This field is used for verification that the medication taken was actually an antiretroviral medication.
- It is not necessary to list all medications, only one. However, more can be listed if there is space. Enter "unspecified" if an ARV was taken but the name is not known.
- Refer to Appendix C of the Guidance for Collection and Data Entry of HIV Incidence Surveillance Information for a list of ARV medications.

12.10 DATES ARVS TAKEN: DATE FIRST BEGAN

- Enter the earliest date that the patient ever took ARV's, even if ARV use was sporadic.
- If the first time ARVs were taken occurred after HIV diagnosis, it is very important to enter a date, even an estimated date, later than the date of HIV diagnosis.
- Enter date in *mmddyyyy* format.

12.11 DATES ARVS TAKEN: DATE OF LAST USE

- Enter the last known date of ARV use.
- For patients currently on ARV's, record the date of the last prescription or known usage. If the information is collected during a patient interview, the date would be the interview date. If the information was collected as part of a medical record review, record the date of the last prescription or date of the last physician's note.
- Enter date in *mmddyyyy* format.

13. COMMENTS AND LOCAL/OPTIONAL FIELDS

13.1 COMMENTS (**Optional**)

- This section can be used for information not requested on the form or for information requested but where there might not be room in the space provided. For example, surveillance staff may document investigative progress toward ascertainment of risk factor information.
- This information is not sent to CDC.

13.2 LOCAL FIELDS/OPTIONAL FIELDS

- This section is for collection of data that is not on the form at the state and local level.
- This information is not sent to CDC.