**GEORGIA ADULT HIV/AIDS CONFIDENTIAL CASE REPORT FORM**

**(Patients ≥ 13 years of age at time of diagnosis)**

**Mail completed form to: Georgia Department of Public Health, Epidemiology Section P.O. Box 2107 Atlanta, GA 30301**

For additional information: Phone: 1-800-827-9769 or visit our website at <http://dph.georgia.gov/reporting-forms-data-requests>

All health care providers AND HIV/AIDs testing sites diagnosing and/or providing care to a patient with HIV are obligated to report using Georgia HIV/AIDS Case Report. Case reports should be completed within seven (7) days after diagnosing or providing care to a patient with HIV/AIDS. Providers are required to submit reports on any patient new to his or her care, regardless if they have previously received care elsewhere.

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| **Date Form Completed:** **/****/** | | | **State # (GDPH Use Only):** | | | | | |
| **I. Patient Name** (last name, first name, and middle initial) **and Address.** | | | | | | | | |
| Patient's Name: | | | | Alias/Maiden: | | | Phone No. : | |
| Current Address: | | City: | | County: | State: | | | ZIP Code: |
| Counseling & Testing No. | Other ID No. Type (e.g Ryan White,TB, ETC) | | | Social Security Number (SSN) :       -     - | | Country: | | |

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| **II. Demographic Information** | | | | | | | |
| Diagnostic Status at Report:  HIV infection (not AIDS)  AIDS | Date of Birth:  Month Day Year        /      / | | Sex at Birth:  Male  Female  Unknown | | Current Gender Identity:  Male   Transgender  Female   Male to Female  Female to Male | | |
| Country of Birth:    Unknown | Alias Date of Birth:  Month Day Year        /      / | | Vital Status:  Alive  Dead  Unknown | | Date of Death:  Month Day Year        /      / | | State of Death: |
| Race:  American Indian or Alaska Native  Native Hawaiian / Other Pacific Islanders  Asian  Black or African American  White  Unknown | | Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Unknown | | | | | |
| **Residence at Diagnosis** | | | | | |
| Address: | | | | City: | |
| State/Country: | | County: | | ZIP Code: | |
| Residence of Diagnosis for:  HIV  AIDS | | **Same address as current address** | | | |

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| **III. Facility** | | | | | | |
| AIDS diagnosis | HIV diagnosis | Facility of Diagnosis: | | | | |
| Address        City: County: State: ZIP Code: | | City | County | State/Country | | ZIP Code |
| Provider Name: | | | | | Provider Specialty: | |
| Provider Phone No.      -     - | | Patient’s Medical Record No. | | |  | |
| Person Completing Form: | | | | | Phone No. | |
| Facility of Person Completing Form (If different from Diagnostic facility): | | | | |  | |
| Address       City:       County  State: ZIP Code: | | | | | Zip code | |

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| **IV. Patient History** | | | | | | | |
| Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories): | | | | | YES | NO | UNK. |
| * Sex with male | | | | |  |  |  |
| * Sex with female | | | | |  |  |  |
| * Injected non-prescription drugs | | | | |  |  |  |
| * **HETEROSEXUAL relations with any of the following:** | | | | |  |  |  |
| Intravenous/injection drug user | | | | |  |  |  |
| Bisexual male | | | | |  |  |  |
| Person with AIDS or documented HIV infection, risk not specified | | | | |  |  |  |
| * Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section) | | | |  |  |  |  |
| First date received |  | Last date received |  | |  |  |  |
| * Worked in a healthcare or clinical laboratory setting   specify occupation and setting (if applicable): | | | | |  |  |  |
| Other risk Transplant Received clotting factor  describe other risk: | | | | |  |  |  |

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| **V. DOCUMENTED LABORATORY DATA** | | | | | | | | | | |
| **HIV Antibody Tests at Diagnosis (**FIRSTpositive test) | | | | | | | | | |  |
|  | | | **+** | **-** | | **Indet** | **Mon** | **DAY** | | **YR** |
| HIV-1 EIA | | |  |  | |  |  |  | |  |
| HIV-1/2 EIA | | |  |  | |  |  |  | |  |
| HIV-1 Western Blot | | |  |  | |  |  |  | |  |
|  | | |  |  | |  |  |  | |  |
| Other (IFA, HIV-1/2 Ag/Ab) | | |  |  | |  |  |  | |  |
| **Earliest Positive HIV Detection** | | | | | | | | | |  |
| Qual PCR DNA p24 antigen | | | | | | |  |  | |  |
| Qual PCR RNA NAAT | | | | | | |  |  | |  |
| **CD4 Count** | | | | | | | | | | |
|  | | cells/ìl | | | % | | **Mon** | **DAY** | **YR** | |
| At or closest to HIV diagnosis | |  | | |  | |  |  |  | |
| First <200 or <14% OR at first AIDS OI | |  | | |  | |  |  |  | |
| **Detectable HIV Viral Load** | | | | | | |  |  |  | |
|  | Type | Copies/mL | | | | | **Mon** | **DAY** | **YR** | |
| Earliest |  |  | | | | |  |  |  | |
| Most Recent |  |  | | | | |  |  |  | |
| **Specify Type**:**1-**NASBA,  **2-**RT-PCR (standard)  **3-**RT-PCR (ultrasen)  **4-**bDNA-v. 2  **5-**bDNA-v. 3 | | | | | | | **Mon** | **DAY** | **YR** | |
| **Physician Diagnosis:** If HIV lab tests were not documented, is HIV diagnosis documented by a physician? **Yes** **No** | | | | | | |  |  |  | |

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| **VI. TREATMENT Yes No Unk** | | | |
| Is patient aware of HIV/AIDS Infection? |  |  |  |
| Receiving or has been referred for HIV medical services? |  |  |  |
| Receiving or has been referred for Substance Abuse services? |  |  |  |
| Receiving Anti-retroviral therapy? |  |  |  |
| Current Co-Infection? Date of Diagnosis.  Hepatitis (B or C) Date:  TB Date:  Gonorrhea/ Chlamydia Date:  Syphilis Date: | | | |
| HIV medical Treatment Reimbursed?  None  Private Insurance  Medicaid  Other  Medicare/Medicaid   Unknown  Clinical Trial | | | |
| **VII. For Female Patient** | | | |
| Is this patient currently pregnant?  Yes No Unknown  If **YES**, enter expected date of delivery:      /     /  This patient is receiving or has been referred for gynecological or obstetrical services:  Yes No Unknown  If **YES**, enter OB/GYN:  \_     \_\_  Has this patient delivered live-born infants?  Yes No Unknown  If **YES**, enter Name and DOB: | | | |

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| **VIII. Comments** (Please list any AIDs Related Opportunistic Infections, test, etc…) |
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**VI. DOCU**