**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 **[ ]** UnknownIf **YES**, enter expected date of delivery:      /     /     This patient is receiving or has been referred for gynecological or obstetrical services: **[ ]** Yes **[ ]** No **[ ]** UnknownIf **YES**, enter OB/GYN:\_     \_\_Has this patient delivered live-born infants?**[ ]** Yes **[ ]** No **[ ]** UnknownIf **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**