

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: () _____
 (Last, First, M.I.)
 Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

- Patient identifier information is not transmitted to CDC! -

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
 Centers for Disease Control and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
 (Patients ≥13 years of age at time of diagnosis)



II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2006

DATE FORM COMPLETED: Mo. Day Yr. [][] [][] [][]

REPORT SOURCE: [][]

SOUNDEX CODE: [][][][][]	REPORT STATUS: 1 New Report 2 Update	REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____	State Patient No.: [][][][][][][][][]
			City/County Patient No.: [][][][][][][][][]

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): 1 HIV Infection (not AIDS) 2 AIDS	AGE AT DIAGNOSIS: [][] Years [][] Years	DATE OF BIRTH: Mo. Day Yr. [][][][][]	CURRENT STATUS: Alive Dead Unk. [] [] []	DATE OF DEATH: Mo. Day Yr. [][][][][]	STATE/TERRITORY OF DEATH: _____
SEX: 1 Male 2 Female	ETHNICITY: (select one) 1 Hispanic 9 Unk 2 Not Hispanic or Latino	RACE: (select one or more) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk	COUNTRY OF BIRTH: (including) 1 U.S. 7 U.S. Dependencies and Possessions Puerto Rico (specify): _____ 8 Other (specify): _____ 9 Unk		
RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: [][][][][][][][]					

IV. FACILITY OF DIAGNOSIS

Facility Name: _____
 City: _____
 State/Country: _____

FACILITY SETTING (check one)
 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one)
 01 Physician, HMO 31 Hospital, Inpatient
 88 Other (specify): _____

This report to the Centers for Disease Control and Prevention (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/AIDS. Information in CDC's HIV/AIDS 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 on file at the local health department, 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).

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify 1 Factor VIII 2 Factor IX 8 Other disorder: (Hemophilia A) (Hemophilia B) (specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
Mo. Yr. First [][][][] Last [][][][]			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

VI. LABORATORY DATA

<p>1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate <u>first</u> test)</p> <table border="1"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Ind</th> <th>Not Done</th> <th>TEST DATE</th> </tr> <tr> <th></th> <th></th> <th></th> <th></th> <th></th> <th>Mo. Yr.</th> </tr> </thead> <tbody> <tr> <td>• HIV-1 EIA</td> <td>1</td> <td>0</td> <td>-</td> <td>9</td> <td>[][][][]</td> </tr> <tr> <td>• HIV-1/HIV-2 combination EIA</td> <td>1</td> <td>0</td> <td>-</td> <td>9</td> <td>[][][][]</td> </tr> <tr> <td>• HIV-1 Western blot/IFA</td> <td>1</td> <td>0</td> <td>8</td> <td>9</td> <td>[][][][]</td> </tr> <tr> <td>• Other HIV antibody test (specify): _____</td> <td>1</td> <td>0</td> <td>8</td> <td>9</td> <td>[][][][]</td> </tr> </tbody> </table> <p>2. POSITIVE HIV DETECTION TEST: (Record <u>earliest</u> test)</p> <p><input type="checkbox"/> culture <input type="checkbox"/> antigen <input type="checkbox"/> PCR, DNA or RNA probe</p> <p>Mo. Yr. [][][][]</p> <p>• Other (specify): _____</p> <p>3. DETECTABLE VIRAL LOAD TEST: (Record <u>most recent</u> test)</p> <table border="1"> <thead> <tr> <th>Test type*</th> <th>COPIES/ML</th> <th>Mo. Yr.</th> </tr> </thead> <tbody> <tr> <td>[][]</td> <td>[][][][][]</td> <td>[][][][]</td> </tr> </tbody> </table> <p>*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other</p>		Pos	Neg	Ind	Not Done	TEST DATE						Mo. Yr.	• HIV-1 EIA	1	0	-	9	[][][][]	• HIV-1/HIV-2 combination EIA	1	0	-	9	[][][][]	• HIV-1 Western blot/IFA	1	0	8	9	[][][][]	• Other HIV antibody test (specify): _____	1	0	8	9	[][][][]	Test type*	COPIES/ML	Mo. Yr.	[][]	[][][][][]	[][][][]	<p>• Date of last documented <u>negative</u> HIV test (specify type): _____ Mo. Yr. [][][][]</p> <p>• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes No Unk. [] [] []</p> <p>Mo. Yr. [][][][]</p> <p>If yes, provide date of documentation by physician _____</p> <p>4. IMMUNOLOGIC LAB TESTS:</p> <p>AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS</p> <p>• CD4 Count _____, [][][] cells/μL Mo. Yr. [][][][]</p> <p>• CD4 Percent _____ % [][][] Mo. Yr. [][][][]</p> <p>First <200 μL or <14% _____, [][][] cells/μL Mo. Yr. [][][][]</p> <p>• CD4 Count _____, [][][] cells/μL Mo. Yr. [][][][]</p> <p>• CD4 Percent _____ % [][][] Mo. Yr. [][][][]</p>
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VII. STATE/LOCAL USE ONLY

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

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED:	Yes <input type="checkbox"/> No <input type="checkbox"/>	ENTER DATE PATIENT WAS DIAGNOSED AS:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Mo. <input type="checkbox"/> Yr. <input type="checkbox"/>	Symptomatic (not AIDS):	Mo. <input type="checkbox"/> Yr. <input type="checkbox"/>
AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.	
Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/> NA	<input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent term)	<input type="checkbox"/> NA	<input type="checkbox"/>	
Candidiasis, esophageal	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent term)	<input type="checkbox"/> NA	<input type="checkbox"/>	
Carcinoma, invasive cervical	<input type="checkbox"/> NA	<input type="checkbox"/>	Lymphoma, primary in brain	<input type="checkbox"/> NA	<input type="checkbox"/>	
Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/> NA	<input type="checkbox"/>	<i>Mycobacterium avium</i> complex or <i>M.kansasii</i> , disseminated or extrapulmonary	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Cryptococcosis, extrapulmonary	<input type="checkbox"/> NA	<input type="checkbox"/>	<i>M. tuberculosis</i> , pulmonary*	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/> NA	<input type="checkbox"/>	<i>M. tuberculosis</i> , disseminated or extrapulmonary*	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/> NA	<input type="checkbox"/>	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<i>Pneumocystis carinii</i> pneumonia	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
HIV encephalopathy	<input type="checkbox"/> NA	<input type="checkbox"/>	Pneumonia, recurrent, in 12 mo. period	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	<input type="checkbox"/> NA	<input type="checkbox"/>	Progressive multifocal leukoencephalopathy	<input type="checkbox"/> NA	<input type="checkbox"/>	
Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/> NA	<input type="checkbox"/>	Salmonella septicemia, recurrent	<input type="checkbox"/> NA	<input type="checkbox"/>	
Isosporiasis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/> NA	<input type="checkbox"/>	Toxoplasmosis of brain	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Kaposi's sarcoma	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	Wasting syndrome due to HIV	<input type="checkbox"/> NA	<input type="checkbox"/>	

Def. = definitive diagnosis Pres. = presumptive diagnosis * RVCT CASE NO.:

• If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes No Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	This patient is receiving or has been referred for:										
This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health department <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown	<table border="0"> <tr> <td>• HIV related medical services</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>-</td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Substance abuse treatment services</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	• HIV related medical services	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
This patient received or is receiving:	This patient's medical treatment is <u>primarily</u> reimbursed by:										
<table border="0"> <tr> <td>• Anti-retroviral therapy</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/></td> </tr> <tr> <td>• PCP prophylaxis</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/></td> </tr> </table>	• Anti-retroviral therapy	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	• PCP prophylaxis	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	<table border="0"> <tr> <td><input type="checkbox"/> Medicaid</td> <td><input type="checkbox"/> Private insurance/HMO</td> </tr> <tr> <td><input type="checkbox"/> No coverage</td> <td><input type="checkbox"/> Other Public Funding</td> </tr> <tr> <td><input type="checkbox"/> Clinical trial/government program</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private insurance/HMO	<input type="checkbox"/> No coverage	<input type="checkbox"/> Other Public Funding	<input type="checkbox"/> Clinical trial/government program	<input type="checkbox"/> Unknown
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<input type="checkbox"/> No coverage	<input type="checkbox"/> Other Public Funding										
<input type="checkbox"/> Clinical trial/government program	<input type="checkbox"/> Unknown										
<p>FOR WOMEN:</p> <ul style="list-style-type: none"> • This patient is receiving or has been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Has this patient delivered live-born infants? <input type="checkbox"/> Yes (if delivered after 1977, provide birth information below for the most recent birth) <input type="checkbox"/> No <input type="checkbox"/> Unknown 											

CHILD'S DATE OF BIRTH: Mo. Day Yr. <input type="checkbox"/>	Hospital of Birth: _____ City: _____ State: _____	Child's Soundex: <input type="checkbox"/>	Child's State Patient No. <input type="checkbox"/>
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X. COMMENTS: _____