



# Florida Adult HIV/AIDS Confidential Case Report

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

## I. HEALTH DEPT USE ONLY

Date Received at Health Department ____/____/____		Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		State Number	
Document Source A - - - -		Surveillance Method A F P R		Report Medium <input type="checkbox"/> Field Visit <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Phone <input type="checkbox"/> Electronic Transfer <input type="checkbox"/> CD/Disk	
Report Status <input type="checkbox"/> New <input type="checkbox"/> Update		Rptg. CHD City		Date form completed: ____/____/____	

## II. PATIENT IDENTIFIER INFORMATION-*data not transmitted to CDC*

Patient Name Last Name First Name Middle Name				Social Security Number	
Address <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary			Current Street Address		
City		State		Zip Code	
				County	
Phone ( )					
City/County Patient Number					

## III. DEMOGRAPHIC INFORMATION-*complete ALL fields*

Diagnostic Status <input type="checkbox"/> HIV <input type="checkbox"/> AIDS		Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth ____/____/____	
Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other (specify):				Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead	
Date of Death ____/____/____			State/Territory of Death		
Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male-to-Female (MTF) <input type="checkbox"/> Transgender Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional gender identity (specify)					
Ethnicity (select one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown					
Race: (select all that apply) <input type="checkbox"/> Black/AA <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> White <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unknown					
Residence at Diagnosis: <input type="checkbox"/> Same as Current Street Address:					
City:		County:		State/Country:	
Zip:					

## IV. FACILITY OF DIAGNOSIS

Facility Name:	
Address:	
City:	
State/Country:	Zip:
Facility Type (check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other	
Facility Code:	
Facility Setting (check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Other	
Provider Name (Last, First, MI)	
Provider Ph. No. ( )	
Med. Rec. No:	
Person Completing Form (Last, First, MI)	
Phone No. ( )	

## V. PATIENT HISTORY- *complete ALL fields*

<b>Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had</b> (Respond to ALL Categories)			
	Yes	No	Unk
Sex with male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injected non-prescription drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factor for hemophilia/coagulation disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify disorder: <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other (specify):			
<b>HETEROSEXUAL relations with any of the following:</b>			
Intravenous/Injection Drug User.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual male ( <b>applies to females only</b> ).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia/coagulation disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplant recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with AIDS or documented HIV infection, risk unspecified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received transfusion of blood/blood components (other than clotting factor) First Date: ____/____/____ Last Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received organ transplant, tissue or artificial insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worked in healthcare or clinical laboratory.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(specify occupation): _____			
Other documented risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**VI. LABORATORY DATA**

HIV Antibody Tests at Diagnosis (Indicate first test-mm/dd/yyyy)			HIV Detection Tests: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 NAT		
HIV-1/2 EIA			HIV-1 Qual PCR RNA		
HIV -1/2 Ag/Ab			HIV-1 P24 Antigen		
HIV-1/2 Differentiating (e.g., Multispot)			HIV-1 Qual PCR DNA		
			Other		
HIV-1 Western Blot/IFA			Other		
Other			Other		
Other			Other		
Viral Load Test: ( most recent test- mm/dd/yyyy)			Immunologic Lab Test: (test date-mm/dd/yyyy)		
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date	
HIV-1 NASBA			CD4 Count: _____ cells/ul ( _____ %)		
HIV-1 RT-PCR			<b>First&lt;200 or &lt;14% of total lymphocytes</b>		
HIV-1 bDNA			CD4 Count: _____ cells/ul ( _____ %)		
Other					

**Physician Diagnosis:**

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?  Yes  No  Unknown

If yes, enter date of diagnosis (mm/dd/yyyy) \_\_\_\_\_

**VII. CLINICAL STATUS**

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date mm/dd/yyyy	Def.	Pres.		Initial DxDate mm/dd/yyyy	Def.	Pres.
	___/___/___	<input type="checkbox"/>		Lymphoma, Burkitt's (or equivalent term)	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent terms)	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>		Lymphoma, primary in brain	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>		M. tuberculosis, pulmonary *	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>		M. tuberculosis, disseminated, or extrapulmonary *	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>		Pneumonia, recurrent, in 12 mo. period	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>		Progressive multifocal leukoencephalopathy	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>		Salmonella septicemia, recurrent	___/___/___	<input type="checkbox"/>	
	___/___/___	<input type="checkbox"/>		Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Wasting syndrome due to HIV	___/___/___	<input type="checkbox"/>	

Def. = definitive diagnosis Pres. = presumptive diagnosis

\* RVCT Case Number \_\_\_\_\_

**VIII. TREATMENT/SERVICES REFERRALS**

Patient informed of his/her 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

**WOMEN ONLY**

Is patient receiving or been referred for obstetrical or gynecological services?  Yes  No  Unknown

Is patient currently pregnant?  Yes  No  Unknown

If YES, EDC (due date) / /

Has patient delivered a live-born infant?  Yes  No  Unknown

**CHILD OF PATIENT (record most recent birth in these boxes; record additional or multiple births in the Comments section)**

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Name (Last, First, MI) \_\_\_\_\_ Child's State No: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

