Patient Identification (record all dates as mm/dd/yyyy)

*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 Address, Street	Address Date __ __/__ __/__ __ __ __

*Phone	City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type	*Number Social Security

U.S. Department of Health and Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis) *Information NOT transmitted to CDC

Centers for Disease Control and Prevention (CDC)

Health Department Use Only (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 06/30/2019

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID	State Number

Reporting Health Dept—City/County St. Petersburg / Pinellas	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

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

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/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Type

(check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address

*Street Address			
City	**County**	**State/Country**	***ZIP Code**

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

STATE/LOCAL USE ONLY	
*Provider Name (Last, First, M.I.)	* Phone
Hospital/Facility	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ 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**	

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

Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, please describe:* Date of evidence __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses

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

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __/__ __/__ __ __ __ ☐ **Point-of-care rapid test**

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __/__ __/__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay** (differentiates between HIV-1 Ab and HIV-2 Ab) **Role of test in diagnostic algorithm** ☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __/__ __/__ __ __ __ ☐ **Point-of-care rapid test**
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate [1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid
Collection Date __ __/__ __/__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
Collection Date __ __/__ __/__ __ __ __ ☐ **Point-of-care rapid test** [2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __/__ __/__ __ __ __

HIV Detection Tests (Quantitative viral load) **Note: Include earliest test at or after diagnosis.**

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __/__ __/__ __ __ __

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __/__ __/__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) **Test brand name/Manufacturer** _____
Lab name _____ **Facility name** _____
Provider name _____ **Collection Date** __ __/__ __/__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __/__ __/__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

First CD4 result <200 cells/µL or <14%: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __/__ __/__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __/__ __/__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm __ __/__ __/__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis __ __/__ __/__ __ __ __

Date of last documented negative HIV test (before HIV diagnosis date) __ __/__ __/__ __ __ __
Specify type of test:

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

Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments)
☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __ __/__ __/__ __ __ __

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 Comments)

***Child's Name**

Child's Date of Birth __ __/__ __/__ __ __ __

Child's Last Name Soundex

Child's State Number

Facility Name of Birth
(if child was born at home, enter "home birth")

***Phone**

Facility Type
Inpatient: ☐ Hospital ☐ Other, specify_____
Outpatient: ☐ Other, specify _____
Other Facility: ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address**

***ZIP Code**

City

County

State/Country

Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one)
☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PrEP	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PEP	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PMTCT	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ HBV Tx	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ Other (specify reason)_____			
	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __

HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one)
☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown **Date of first positive HIV test** __ __/__ __/__ __ __ __

Ever had a negative HIV test? ☐ Yes ☐ No ☐ 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 the 24 months before the first positive test __ __ ☐ Unknown

Comments

☐ CHECK OOS STATE:_____ If pregnant, list EDD (due date): / /

If previous positive, what state/s was the patient diagnosed/treated in?

Circle if patient has history of any of the following: drug abuse; opiate use; prostitution/sex with prostitute; STD diagnosis; multiple heterosexual partners; mental illness; victim of sexual assault ; jail

Link with e-HARS stateno (s):

*Local/Optional Fields

NIR STATUS:

PRISM#_____DOC#_____ NIR OP___ Date:___/___/_____

Other Risks: A___B/C___D___F___M___V___J___O___ NIR CL ___ Date ___/___/_____

Hepatitis: A___B___C___Other___Unknown___ NIR RE ___ Date ___/___/_____

Test and Treat (Yes/No): Initials (3)____Source code:_____

This report to 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. Information in CDC's National HIV 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).