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

<table>
<thead>
<tr>
<th>Field</th>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Name Type</td>
<td>□ Birth □ Maiden □ Other</td>
<td>Specify other name type</td>
</tr>
<tr>
<td>Current Address, Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Medical Record Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Resident at Diagnosis

- **Patient Demographics**
  - **Sex Assigned At Birth**
  - **Country of Birth**
  - **Date of Birth**
  - **Vital Status**
  - **Current Gender Identity**
  - **Ethnicity**
  - **Race**

### Residence at Diagnosis (add additional addresses in Comments)

- **Address Type**
- **Address Event Type**
- **Address**
  - **Street Address**
  - **HIV**
  - **AIDS**
  - **ZIP Code**

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**Additional Information**

- **Collection of Information**
- **U.S. Department of Health and Human Services**
- **Centers for Disease Control and Prevention (CDC)**

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**Form approved OMB no. 0920-0573 Exp. 11/30/2022**

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**KY REVISED FORM 02/2020 ADAPTED FROM CDC 50.42A Rev. 11/2019 (Page 1 of 4)**

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**—ADULT HIV CONFIDENTIAL CASE REPORT—**
Clinical Issues

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Sex with male
Sex with female

Injected nonprescription drugs

Received clotting factor for hemophilia/coagulation disorder
Specify clotting factor: Date received □□/□□/□□

HETEROSEXUAL relations with any of the following:

HETEROSEXUAL contact with intravenous/injection drug user
HETEROSEXUAL contact with bisexual male
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection
HETEROSEXUAL contact with transfusion recipient with documented HIV infection
HETEROSEXUAL contact with transplant recipient with documented HIV infection
HETEROSEXUAL contact with person with documented HIV infection, risk not specified

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)

First date received □□/□□/□□ Last date received □□/□□/□□

Received transplant of tissue/organs or artificial insemination

Worked in a healthcare or clinical laboratory setting

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)

Diagnosis

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.

Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphenopahathy)? Date of sign/symptom onset □□/□□/□□

Other evidence suggestive of acute HIV infection? If YES, please describe: Date of evidence □□/□□/□□

Opportunistic Illnesses

Diagnosis

Candidiasis, bronchi, trachea, or lungs
Candidiasis, esophageal
Carcinoma, invasive cervical
Coccidioidomycosis, disseminated or extrapulmonary
Cryptosporidiosis, extrapulmonary
Cryptococcosis, extrapulmonary
Cytomegalovirus disease (other than in liver, spleen, or nodes)
Cytomegalovirus retinitis (with loss of vision)
HIV encephalopathy

Diagnosis

Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis
Histoplasmosis, disseminated or extrapulmonary
Isosporiasis, chronic intestinal (>1 mo. duration)
Kaposi’s sarcoma
Lymphoma, Burkitt’s (or equivalent)
Lymphoma, immunoblastic (or equivalent)
Lymphoma, primary in brain
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
Taxoplasmosis of brain, onset at >1 mo. of age

Diagnosis

M. tuberculosis, pulmonary
M. tuberculosis, disseminated or extrapulmonary
Mycobacterium, of other/unidentified species, disseminated or extrapulmonary
Pneumocystis pneumonia
Pneumocystis recurrent, in 12 mo. period
Progressive multifocal leukoencephalopathy
Salmonella septicemia, recurrent
Taxoplasmosis of brain, onset at >1 mo. of age
Wasting syndrome due to HIV

1 If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:
If YES, provide specimen collection date  

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria?  □ Yes  □ No  □ Unknown  

Overall interpretation: Role of test in diagnostic algorithm  □ Screening/initital test  □ Confirmatory/supplemental test  

Analyte results: HIV-1 Ab: □ Positive  □ Negative  □ Indeterminate  □ Point-of-care rapid test  

Analyte results: HIV-2 Ab: □ Positive  □ Negative  □ Indeterminate  □ Point-of-care rapid test  

Analyte results: HIV-1 Ag: □ Reactive  □ Nonreactive  □ Not reportable due to high Ab level  □ Point-of-care rapid test  

Analyte results: HIV-2 Ag: □ Reactive  □ Nonreactive  □ Indeterminate  □ Point-of-care rapid test  

Analyte results: HIV-1 RNA/DNA NAAT (Quantitative): □ Detectable  □ Undetectable  □ Point-of-care rapid test  

Analyte results: HIV-2 RNA/DNA NAAT (Quantitative): □ Detectable  □ Undetectable  □ Point-of-care rapid test  

Analyte results: CD4 count and percentage: □ Detectable  □ Undetectable  □ Point-of-care rapid test  

Documented Tests  

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria?  □ Yes  □ No  □ Unknown  

Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.  

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

If YES, provide date of diagnosis  

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 □ 3-No □ 4-No □ 5-No

Date of medical visit or prescription ______ / ______ / ________ MUST INCLUDE DATE

Referral for HIV Medical Services: □ Yes □ No

Enrolled at (Clinic): □ HRSA Sponsored □ Other □ None □ Unknown

ID Facility Name: ____________________________

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
□ PrEP □ ARV medications
□ PEP □ ARV medications
□ PMTCT □ ARV medications
□ HBV Tx □ ARV medications
□ Other (specify reason)

Date began ______ / ______ / ______ Date of last use ______ / ______ / ______

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”)

Facility Type
□ Inpatient: Hospital □ Outpatient: Other Facility: □ Emergency room
□ Other, specify ____________________________
□ Other, specify ____________________________
□ Other, specify ____________________________

*Street Address ____________________________

City ____________________________ County ____________________________

State/Country ____________________________

ZIP Code ____________________________

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

________________________________________________________________________

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Local/Optional Fields

*DATE REFERRED FOR PARTNER SERVICES (PS): ______ / ______ / ________ Already in NEDSS □ Yes □ No

NEDSS ID #: ____________________________

SOUNDEX:

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).