

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

*First Name		*Middle Name		*Last Name		Last Name Soundex	
Alternate Name Type <input type="checkbox"/> Birth <input type="checkbox"/> Alias <input type="checkbox"/> Maiden <input type="checkbox"/> Other, Specify		*First Name		*Middle Name		*Last Name	
Address Type <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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				*Current Address, Street <input type="checkbox"/> USPS Check			Address Date
*Phone		City		County		State	*ZIP Code
*Medical Record Number		KY Testing/EvaluWeb Number (KY Number)			*SSN Alias *SSN		

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 revised for KY use from OMB no.0920-0573

Date Received at Health Department		Surv. Investigator		KY State Number		
Document Source		Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown <input type="checkbox"/> A05 <input type="checkbox"/> NIC List <input type="checkbox"/> Other				
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 6-CD/disk				

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone		
*Street Address					
City		County		State/Country	*ZIP Code
Date Form Completed <input type="checkbox"/> Same as Date Received _____			*Person Completing Form:		*Phone

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

Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (specify)			
Date of Birth			Alias Date of Birth		
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead		Date of Death		State of Death	
Gender Identity <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Transgender man <input type="checkbox"/> Transgender woman <input type="checkbox"/> Additional gender identity (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown					
Date Identified _____					
Sexual Orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Additional sexual orientation (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown					
Date Identified _____					
Ethnicity		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown			Expanded Ethnicity
Race (check all that apply)		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown			Expanded Race

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

Address Event Type (check all that apply) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Check if <u>SAME</u> as current address					
Address Type <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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary					
*Street Address					
HIV: City		County		State/Country	*ZIP Code
AIDS: 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.

Closed _____ eHARS _____ SCAN _____

***Ordering Provider Name:**

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis	(check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Check if <u>SAME</u> as facility providing information		
Facility Name	*Phone		
*Street Address			
City	County	State/Country	*ZIP Code
*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:		<input type="checkbox"/> All Risks Unknown
Sex with male		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: _____ Date received: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:		
HETEROSEXUAL contact with intravenous/injection drug user		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received _____ Last date received _____		
Received transplant of tissue/organs or artificial insemination		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

Suspect acute HIV infection? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset _____ MUST INCLUDE DATE	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other evidence suggestive of acute HIV infection? <i>If YES, please describe:</i> Date of evidence _____ MUST INCLUDE DATE	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Opportunistic Illnesses <input type="checkbox"/> NONE					
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	

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

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

HIV Immunoassays			
TEST <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Point-of-care rapid test by provider			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date _____	
TEST <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Point-of-care rapid test by provider			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date _____	
TEST <input type="checkbox"/> 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 Overall: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		Collection Date _____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-1/2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive			
TEST <input type="checkbox"/> 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 ³ Overall interpretation: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index Value _____		Collection Date _____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level Index Value _____			
HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____			
HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____			
TEST <input type="checkbox"/> HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab) *GEENIUS			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result Overall interpretation: <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-1 positive with HIV-2 cross-reactivity <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity			
<input type="checkbox"/> HIV negative <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive			
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date _____	
HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate			
HIV Detection Tests			
TEST <input type="checkbox"/> HIV-1/2 RNA NAAT (Qualitative)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (HIV-1 and HIV-2) <input type="checkbox"/> HIV, not differentiated (HIV-1 or HIV-2) <input type="checkbox"/> Neither (negative)		Collection Date _____	
TEST <input type="checkbox"/> HIV-1 RNA NAAT (Qualitative and Quantitative)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result Qualitative: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		Collection Date _____	
Analyte results: HIV-1 Quantitative: <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit <input type="checkbox"/> Not Detected			
		Copies/mL _____ Log _____	
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date _____	
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit <input type="checkbox"/> Not detected		Copies/mL _____	
Collection Date _____		Log _____	
Drug Resistance Tests (Genotypic)			
TEST <input type="checkbox"/> HIV-1 Genotype (Unspecified)			
Lab Name _____		Test Brand Name/Manufacturer _____	
Provider Name _____		Facility Name _____	
		Collection Date _____	
Immunologic Tests (CD4 count and percentage)			
CD4 count _____ cells/uL		CD4 percentage _____ %	
Test Brand Name/Manufacturer _____		Collection Date _____	
Facility Name _____		Lab Name _____	
		Provider Name _____	
Documentation of Tests			
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, provide specimen collection date of earliest positive test result for this algorithm			
<i>Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.</i>			
Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, provide date of diagnosis by physician _____			
Date of last documented negative HIV test result (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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	This patient's partners will be notified about their HIV exposure and counseled by <input type="checkbox"/> 1-Health dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) <input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 2-Yes, client self-report, only Date of medical visit or prescription _____ MUST INCLUDE DATE	
Receiving or Referred for HIV Medical Services: <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled at (Clinic): <input type="checkbox"/> HRSA Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
ID Facility Name: _____	

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

Main source of antiretroviral (ARV) use information (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other	Date patient reported information
Ever taken any ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, reason for ARV use (select all that apply) Check box if ARV is ongoing	
<input type="checkbox"/> HIV Tx ARV medications _____ Date began _____ Date of last use _____ <input type="checkbox"/>	
<input type="checkbox"/> PrEP ARV medications _____ Date began _____ Date of last use _____ <input type="checkbox"/>	
<input type="checkbox"/> PEP ARV medications _____ Date began _____ Date of last use _____ <input type="checkbox"/>	
<input type="checkbox"/> PMTCT ARV medications _____ Date began _____ Date of last use _____ <input type="checkbox"/>	
<input type="checkbox"/> HBV Tx ARV medications _____ Date began _____ Date of last use _____ <input type="checkbox"/>	
<input type="checkbox"/> Other (specify reason) _____ Date began _____ Date of last use _____ <input type="checkbox"/>	

For Assigned Female at Birth Patient

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 <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____
	<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____
*Street Address	*ZIP Code
City	State/Country

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

Main source of testing history information (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other	Date patient reported information
Ever had previous positive HIV test result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of first positive HIV test result: _____	
Was the first positive test result from a self-test performed by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Ever had a negative HIV test result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of last negative HIV test result (if date is from a lab test with test type, enter in Lab Data section) _____	
Last neg test a self-test performed by patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Number of negative HIV test results within the 24 months before the first positive test result _____ <input type="checkbox"/> Unknown	
How many of these negative test results were from self-tests performed by the patient? _____ <input type="checkbox"/> Unknown	

Comments

*Internal Comments	*DATE REFERRED FOR PARTNER SERVICES (PS): _____	Referred by: _____
SOUNDEX: _____		
Lexis Nexis: _____		
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).		