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

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type ☐ Birth ☐ Alias ☐ Maiden ☐ Other, Specify	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street ☐ USPS Check		Address Date
*Phone	City	County	State/Country	*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 approved OMB no. 0920-0573 Exp. 11/30/2022

Date Received at Health Department	KY State Number
Reporting Health Dept—City/County	City/County Number
Document Source	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown ↳ ☐ A05 ☐ D2C ☐ Other
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 ☐ Same as Date Received _____	*Person Completing Form Surv. Investigator:		*Phone

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

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Unknown ☐ 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 Event Type (check all that apply) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address			
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary			
*Street Address			
HIV: City	County	State/Country	*ZIP Code
AIDS: City	County	State/Country	*ZIP Code

☐ Closed _____ ☐ eHARS _____ ☐ SCAN _____

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)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	☐ **All Risks Unknown**
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 **MUST INCLUDE DATE**	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, please describe:* Date of evidence **MUST INCLUDE DATE**	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses ☐ **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	

[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 _____
Facility name
☐ **P-24 Antigen Only***
☐ Reactive ☐ Nonreactive ☐ Not Reportable
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**
Facility 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** _____

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

CD4 at or closest to diagnosis: 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 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 _____

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 _____ **MUST INCLUDE DATE**	
Referred 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)

				Check box if ARV is ongoing
☐ 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	☐

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

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

*Local/Optional Fields

*DATE REFERRED FOR PARTNER SERVICES (PS): Already in NEDSS ☐ Yes ☐ No NEDSS ID #:

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).