ADULT HIV/AIDS CASE REPORT FORM
(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Use *(Record All Dates as mm/dd/yyyy)*

**** Required Sections/Fields.***

*Name of Person Completing Form:	*Person's Phone Number: ( )	*STATENO:	CITYNO:
*Date Form Completed: _____/_____/_____	*Reporting Health Department - City/County:	*Document Source:	
Physician's Name:	Physician's Phone Number: ( )	Hospital/Facility Name:	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Surveillance Method: ☐ Active ☐ Passive ☐ Follow Up ☐ Reabstraction ☐ Unknown	Report Medium: ☐ 1- Field Visit ☐ 2- Mailed ☐ 3- Phone ☐ 4- Electronic Transfer ☐ 5- CD/Disk	

II. Patient Identification

*Patient Last Name:	*Middle Name:	*First Name:	
Alternate Name Type *(e.g. Alias, Married, etc.)*:	Last Name:	Middle Name:	First Name:
*Address Type: ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary			
*Current Street Address:	*City:	*County:	
*State/Country:	*ZIP Code:	*Phone Number: ( )	*Social Security Number:	Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:	

III. Patient Demographics *(Record All Dates as mm/dd/yyyy)*

*Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other/U.S. Dependency *(please specify)*: _____	*Date of Birth: _____/_____/_____

Alias Date of Birth: _____/_____/_____	*Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: _____/_____/_____	State of Death:	*Status: ☐ HIV ☐ AIDS

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:

Expanded Race:

*Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islande
☐ Chinese ☐ Vietnamese ☐ Hawaiian
☐ Japanese ☐ Asian Indian ☐ Guamanian
☐ Filipino ☐ Laotian ☐ Samoan
☐ Korean ☐ Cambodian
☐ Other *(specify)*: _____

IV. *Residence at Diagnosis *(Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)*

Address Type *(check all that apply)*: ☐ Residence at HIV Diagnosis ☐ Residence at AIDS Diagnosis ☐ Check if SAME as Current Address

	Street Address:	City:	County:	State/Country:	ZIP Code:
Address of Residence at HIV Diagnosis					
Address of Residence at AIDS Diagnosis					

V. *Facility at Diagnosis *(Add Additional Facilities in Comments and Local/Optional Fields Section)* STATENO: _____ MEDREC# / ID: _____

Diagnosis Type *(check all that apply to facility):* ☐ HIV Diagnosis ☐ AIDS Diagnosis ☐ Check if SAME as Facility Providing Information			
Facility Name:	Phone Number: ( )	Street Address:	City:
County:	State/Country:	ZIP Code:	Provider Name:

Facility Type:

Inpatient: ☐ Hospital ☐ Other *(specify):* _____

Outpatient: ☐ Private Physician ☐ Adult HIV Clinic ☐ Other *(specify):* _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other *(specify):* _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other *(specify):* _____

VI. *Patient History *(Respond to All Questions)*

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with a male: ☐ Yes ☐ No ☐ Unknown Sex with a female: ☐ Yes ☐ No ☐ Unknown Injected non-prescription drugs: ☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL relations with any of the following:	**Has the patient:**
Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown	Received clotting factor for hemophilia/coagulation disorder: ☐ Yes ☐ No ☐ Unknown
Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown	Received transfusion of blood/blood components *(non-clotting)*: ☐ Yes ☐ No ☐ Unknown
Contact with a person with AIDS or documented HIV infection, risk not specified ☐ Yes ☐ No ☐ Unknown	Perinatally infected *(please enter in comments and local/optional fields section):* ☐ Yes ☐ No ☐ Unknown
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	Other documented risk *(if yes, specify):* ☐ Yes ☐ No ☐ Unknown
Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	_____

VII. *Laboratory Data *(Record All Dates as mm/dd/yyyy) (See Instructions for Details)*

HIV Immunoassays (Non-Type Differentiating)

TEST 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

HIV Immunoassays (Type Differentiating)

TEST: ☐ **HIV-1/2 Ag/Ab differentiating** (*Differentiates between HIV Ag and HIV Ab*) *(e.g. Determine by Alere)*

RESULT: ☐ HIV Ag ☐ HIV Ab ☐ Both *(Ag and Ab reactive)* ☐ Neither *(negative)* ☐ Invalid/Indeterminate
RAPID TEST *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST: ☐ **HIV-1/2 Ag/Ab and Type-differentiating** (*Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab) (e.g. Bio-Rad BioPlex "5th gen")*

RESULT: Select one result for HIV-1 Ag *and* one result for HIVAb
HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reported
HIV-Ab: ☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
Collection Date: ____/____/_____
Manufacturer: _____

TEST: ☐ **HIV-1/2 Type-differentiating** (*Differentiates between HIV-1 Ab and HIV-2 Ab*) *(e.g. Multispot, Geenius)*

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both *(undifferentiated)* ☐ Neither *(negative)* ☐ Indeterminate
RAPID TEST *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

VII. *Laboratory Data *(continued)* *(Record All Dates as mm/dd/yyyy)*

STATENO: _____ **MEDREC# / ID:** _____

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

HIV Detection Tests (Quantitative Viral Load) ***Note: Include earliest test after diagnosis***

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

Immunologic Tests (CD4 Count and Percentage)

CD4 at or closest to current diagnosis status: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

First CD4 result <200 cells/µL or <14%: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

Other CD4 result <200 cells/µL or <14%: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

Documentation of Tests *(Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA])*

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

If yes, provide date *(specimen collection date if known)* of earliest positive test for this algorithm: ____/____/_____

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

If yes, provide date of documentation by physician: ____/____/_____

VIII. Clinical *(Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)*

	✓	Date		✓	Date
Candidiasis, esophageal			Kaposi's sarcoma		
Cryptococcosis, extrapulmonary			Pneumocystis carinii pneumonia		
Cytomegalovirus disease (other than in liver, spleen or nodes)			Wasting syndrome due to HIV		
Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis			Other *(specify)*:		

IX. Treatment/Services Referrals *(Record All Dates as mm/dd/yyyy)*

Has This Patient Been Informed of His/Her HIV Infection? ☐ Yes ☐ No ☐ Unknown

Patient's Medical Treatment is Primarily Reimbursed by:

☐ 1- Medicaid ☐ 2- Private Insurance/HMO ☐ 3- No Coverage ☐ 4- Other Public Funding ☐ 9- Unknown

For Female Patient:

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 Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)*

Child's Name:	Child's Soundex:	Child's Date of Birth: ____/____/_____	Child's Coded ID:	Child's STATENO:

IX. Treatment/Services Referrals (*continued*) *(Record All Dates as mm/dd/yyyy)*

STATENO: _____ **MEDREC# / ID:** _____

Hospital of Birth: *(If Child Was Born at Home, Enter "Home Birth" for Hospital Name)*			
Hospital Name:	County:		Phone Number: ( )
Street Address:	City:	State/Country:	ZIP Code:

X. *HIV Antiretroviral Use History *(Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)*

Main Source of Antiretroviral (ARV) Use Information *(select one):*

☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other *(specify):* _____

Date Patient Reported Information: _____/_____/_____

Ever Taken Any Antiretrovirals (ARVs)? ☐Yes ☐No ☐Unknown

If Yes, Reason for ARV use (*select all that apply*):

☐ HIV Tx	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____
☐ PrEP	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____
☐ PEP	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____
☐ PMTCT	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____
☐ HBV Tx	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____
☐ Other:	_____		
	ARV med: _____	Date began: ____/____/_____	Date of last use: ____/____/_____

XI. *HIV Testing History *(Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)*

Main Source of Testing History Information *(select one):*

☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other *(specify):* _____

Date Patient Reported Information: _____/_____/_____

Ever Had a Positive HIV Test?	Date of First Positive HIV Test:	Ever Had a Negative HIV Test?	Date of Last Negative HIV Test: *(If date is from a lab test with test type, enter in Laboratory Data Section.)*
☐ Yes ☐ No ☐ Unknown	_____/_____/_____	☐ Yes ☐ No ☐ Unknown	_____/_____/_____

Number of Negative HIV Tests Within 24 Months Before First Positive Test *(#)*: _____ ☐ Unknown

XII. Duplicate Review (Office use)

Status *(check one)*: ☐ Same As ☐ Different Than ☐ Pending	State Name:	*STATENO:

XIII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by: _____ Entered by: _____ Entry Date: _____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
600 S. COMMONWEALTH AVE, 10F - SUITE 1260
LOS ANGELES, CA 90005

TO DOWNLOAD THIS FORM, GO TO HTTP://PUBLICHEALTH.LACOUNTY.GOV/DHSP/REPORTCASE.HTM

TO REPORT THROUGH PHONE, PLEASE CALL (213) 351-8516.

DO NOT SEND THE REPORT BY EMAIL OR FAX.