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/Alaska Native
☐ Asian
- ☐ Chinese ☐ Vietnamese
- ☐ Japanese ☐ Asian Indian
- ☐ Filipino ☐ Laotian
- ☐ Korean ☐ Cambodian

☐ Pacific Islander
- ☐ Hawaiian
- ☐ Guamanian
- ☐ Samoan

☐ 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:

- Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown
- Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown
- Contact with a person with AIDS or documented HIV infection, risk not specified: ☐ Yes ☐ No ☐ Unknown
- Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown
- Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown

Has the patient:

- Received clotting factor for hemophilia/coagulation disorder: Date Received: ______________ ☐ Yes ☐ No ☐ Unknown
- Received transfusion of blood/blood components *(non-clotting)*: Date Received: ______________ ☐ Yes ☐ No ☐ Unknown
- Perinatally infected *(please enter in comments and local/optional fields section)*: ☐ Yes ☐ No ☐ Unknown
- Other documented risk *(if yes, specify)*: ☐ Yes ☐ No ☐ Unknown ______________

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

HIV Immunoassays (Non-differentiating)

TEST: ☐HIV-1 IA ☐HIV-1/2 IA ☐HIV-1/2 Ag/Ab ☐HIV-1 WB ☐HIV-1 IFA ☐HIV-2 IA ☐HIV-2 WB

RESULT: ☐Positive/Reactive ☐Negative/Non-Reactive ☐Indeterminate

Manufacturer: ______________ **Rapid Test** (check if rapid): ☐ **Collection Date:** ______________

HIV Immunoassays (Differentiating)

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

RESULT: ☐HIV Ag ☐HIV Ab ☐Both *(Ag and Ab Reactive)* ☐Neither *(Negative)* ☐Invalid/Indeterminate

Manufacturer: ______________ **Rapid Test** (check if rapid): ☐ **Collection Date:** ______________

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

RESULT: *COMPLETE THE OVERALL INTERPRETATION AND ANALYTE RESULTS*

Overall Interpretation: ☐ Reactive ☐ Non-Reactive Index Value: ________

Analyte Results:
- **HIV-1 Ag:** ☐ Reactive ☐ Non-Reactive ☐ Not reportable due to high HIV Ab level Index Value: ________
- **HIV-1 Ab:** ☐ Reactive ☐ Non-Reactive ☐ Reactive Undifferentiated Index Value: ________
- **HIV-2 Ab:** ☐ Reactive ☐ Non-Reactive ☐ Reactive Undifferentiated Index Value: ________

Manufacturer: ______________ **Collection Date:** ______________

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

Role of test in diagnostic algorithm: ☐ **Initial** ☐ **Supplemental**

RESULT: *ALWAYS COMPLETE THE OVERALL INTERPRETATION. COMPLETE THE ANALYTE RESULTS WHEN AVAILABLE.*

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
- **HIV-2 Ab:** ☐Positive ☐Negative ☐Indeterminate

Manufacturer: ______________ **Rapid Test** (check if rapid): ☐ **Collection Date:** ______________

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:** ________________

Drug Resistance Tests (Genotypic)

TEST: ☐ HIV-1 Genotype (Unspecified) **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, 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: ________________

Date of last documented negative HIV test (before HIV diagnosis date): ________________ Specify type of test: ____________________

VIII. 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)? If YES, provide date of sign/symptom onset: ________________ ☐ Yes ☐ No ☐ Unknown

Other evidence suggestive of acute HIV infection? ☐ Yes ☐ No ☐ Unknown

If YES, please describe: ________________________________ Date of evidence: ________________

OPPORTUNISTIC ILLNESSES

	Dx Date		Dx Date		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:**

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

STATENO: ______________ **MEDREC# / ID:** ______________

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

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 PATIENTS 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 Below; Record Additional or Multiple Births in Comments Section)*

Child's Name:	Child's Soundex:	Child's Date of Birth:	Child's Coded ID:	Child's STATENO:
		____________________		

Hospital Name of Birth: *(If Child was born at Home, Enter "Home Birth" for 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 Testing History 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. 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, 10TH FLOOR - SUITE 1260
LOS ANGELES, CA 90005

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