

Adult HIV/AIDS Confidential Case Report Form

Date Received

(Patients ≥ 13 years of age)

I. HEALTH DEPT USE ONLY

Reporting City (Site)	Report Status	New Investigation	State Number	City Number
<input type="checkbox"/> LAC(CA01) <input type="checkbox"/> LB(CA60) <input type="checkbox"/> PA(CA61)	New Update	Y N U		
Document Source: A (Specify:)	LN Soundex	Surveillance Method	Reporting Medium	
		A F P R U	Field visit Mailed Phone E-Transfer	

II. PATIENT IDENTIFIER INFORMATION – data not transmitted to CDC

Name: (First) _____ (Middle) _____ (Last) _____ Alias: _____ SS#: _____ - _____ - _____

Current Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone: () _____ - _____ Lab Accession Number: _____ Confidential C&T Number: _____

III. FORM INFORMATION

Date form completed: ___/___/___ Person completing form: _____ Phone: () _____ - _____

IV. REPORTING PROVIDER INFORMATION

Physician: _____ last, _____ first _____ middle Facility: _____

City: _____ State: _____ Phone: () _____ - _____

Med Rec No: _____ Date 1st seen: ___/___/___ Date last seen: ___/___/___

V. DEMOGRAPHIC INFORMATION – complete ALL fields

Diagnostic Status: <input type="checkbox"/> Adult HIV <input type="checkbox"/> Adult AIDS	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (MTF) <input type="checkbox"/> Transgender (FTM)	Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Unk <input type="checkbox"/> Other _____	Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Death 8 UY: _____/_____/_____ State/Terr of Death:
Marital Status: S M W D Oth Unk	Date of Birth: ____/____/____	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Race (check all that apply): <input type="checkbox"/> Black/Af. Am <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian/Pac Islander <input type="checkbox"/> Unk <input type="checkbox"/> Other _____		
Education Level: _____ <i>For Hispanics and Asians, please specify extended race: _____</i>					
Residence at Diagnosis: <input type="checkbox"/> Same as Current <input type="checkbox"/> Homeless <input type="checkbox"/> Outside of US. Specify (city/country): _____/_____ HIV: Address: _____ City: _____ County: _____ State: _____ Zip: _____ AIDS: Address: _____ City: _____ County: _____ State: _____ Zip: _____					

VI. FACILITY OF DIAGNOSIS

Facility Name: _____

Physician: _____

Address: _____

City: _____

State: _____ ZIP Code: _____

Facility Type: Private Physician
 Hosp Inpatient Outpatient C&T
 HIV Clinic Emergency Department
 Com HC Oth: _____

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before the 1 st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
➢ Sex with male			
➢ Sex with female			
➢ Injected drugs			
➢ Received clotting factor: <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Oth: _____ Date: ___/___/___			
➢ HETEROsexual relations with the following:			
• Injecting Drug User (IDU)			
• Bisexual male (applies to females only)			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
➢ Received transfusion Date 1 st : ___/___/___ Date last: ___/___/___			
➢ Received organ transplant, tissue or artificial insemination			
➢ Worked in healthcare/clinical laboratory OCCUPATION:			
➢ Perinatally infected			
➢ Other:			

VIII. HIV TESTING AND TREATMENT HISTORY

Date information collected from patient (mm/dd/yy): ___/___/___

Date of first HIV positive ___/___/___

Has ever tested *negative* for HIV? Yes No (this is first HIV test ever)
 Unknown Refused

If yes, date of last negative HIV test: ___/___/___

If yes, how many times did patient test HIV *negative* in the 24 months before the first positive test?
_____ (#) negative tests Unknown Refused

Has used antiretrovirals (ARV)? (Check yes if used for any reason including preventing HIV or treating HBV?)
 Yes No Unknown Refused

If yes, was ARV use: before HIV diagnosis after HIV diagnosis

If yes, list medications: _____

Date of first ARV use (mm/dd/yy): ___/___/___

Date of last ARV use (mm/dd/yy): ___/___/___

Has patient received PCP prophylaxis? Yes No Unk Refused

