ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

I. Patient Information

Patient Last Name:	Middle Name:	First Name:	
Address Type: ☐ Residential ☐ Bad address ☐ Correctional Facility ☐ Foster Home ☐ Postal ☐ Shelter ☐ Temporary			
Current Street Address:	City:	County:	
State/County:	Zip Code:	Phone Number: ( )	Social Security Number:

II. Patient Demographics

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other (please specify) _____	Date of Birth: ___/____/____
Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: ____/_____/_____	Status: ☐ HIV ☐ AIDS
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male-to-Female ☐ Transgender: Female-to-Male ☐ Unknown ☐ Other Gender Identity (specify): _____		Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ Chinese ☐ Vietnamese ☐ Hawaiian ☐ Japanese ☐ Asian Indian ☐ Guamanian ☐ Filipino ☐ Laotian ☐ Samoan ☐ Korean ☐ Cambodian ☐ Other (Specify): _____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		

III. 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	Other documented risk: *(if yes, specify):* _____	☐ Yes ☐ No ☐Unknown
Contact with transplant recipient with documented HIV:	☐ Yes ☐ No ☐Unknown		
Contact with transfusion recipient with documented HIV:	☐ Yes ☐ No ☐Unknown		

Probable Mode of Infection:

☐ Homosexual/Bisexual history ☐ IV Drug Use ☐ Heterosexual contact ☐ Blood Products

Has patient been informed of HIV positive status? ☐ Yes ☐ No

Partner notification offered? ☐ Yes ☐ No

Referred for HIV services? ☐ Yes ☐ No

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IV. Facility at Diagnosis

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 _____ ***Outpatient:*** ☐ Private Physician ☐ Adult HIV Clinic ☐ Other _____ ***Screening, Diagnostic, Referral Agency:*** ☐ CTS ☐ STD Clinic ☐ Other _____ ***Other Facility:*** ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other _____		

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

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]
Test 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB ☐ Other *(specify)*_____
Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** (check if rapid): ☐ **Collection Date:** _____/_____/_____
Test 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB ☐ Other *(specify)*_____
Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** (check if rapid): ☐ **Collection Date:** _____/_____/_____
HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]
Test: ☐ HIV-1/2 Differentiating *(e.g. Multispot)*
Result: ☐ HIV-1 ☐ HIV-2 ☐ Both *(undifferentiated)* ☐ Neither *(negative)* **Collection Date:** _____/_____/_____
HIV Detection Tests (Quantitative Viral Load) ***Note: include earliest test after diagnosis***
Test 1: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ TR-PCR ☐ bDNA ☐ Other *(specify test):* _____
RESULT: ☐ Detectable ☐ Undetectable **Copies/mL: _____ Log: _____ Collection Date:** _____/_____/_____
CD4 at or closest to current diagnosis status: CD4 count: _____ cell/μL **CD4 percentage: _____% Collection Date:** _____/_____/_____

V. HIV Testing and Antiretroviral Use History (TTH) *(Record All Dates as mm/dd/yyyy)*

Main Source of Testing and Treatment 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? ☐ Yes ☐ No ☐ Refused ☐ Don't know/Unknown	Date of First Positive HIV Test: ____/_____/_____	Ever Had a Negative HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of Last Negative Test: *(if data is from a lab test with test type, enter in Laboratory Data Section.)* _____/_____/_____
Number of Negative HIV Tests Within 24 Months Before First Positive Test *(#):*_____ ☐ Refused ☐ Don't known/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: _____/_____/_____	Date ARVs Last Taken *(mm/dd/yyyy):* _____/_____/_____		