

Adult HIV Confidential Case Report Form
(Patients ≥13 years of age at time of diagnosis)

*Information NOT transmitted to CDC

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

Form approved OMB no. 0920-0573 Exp. 02/28/2026

*First Name		*Middle Name		*Last Name		Last Name Soundex	
Alternate Name Type (ex: Alias, Married)		*First Name		*Middle Name		*Last Name	
Address Type							
Residential		Correctional facility		Homeless		Other	
Bad address		Foster home		Military		Postal	
Shelter		Temporary					
*Current Address, Street						Address Date	
						/ /	
*Phone		City		County		State/Country	
						*ZIP Code	
*Medical Record Number		*Other ID Type		*Number			

II. Health Department Use Only (record all dates as mm/dd/yyyy)

Date Received at Health Department		eHARS Document UID		State Number	
/ /					
Reporting Health Dept—City/County				City/County Number	
Document Source		Surveillance Method			
		Active Passive Follow up Reabstraction Unknown			
Did this report initiate a new case investigation?		Report Medium			
Yes No Unknown		1-Field visit 3-Faxed 5-Electronic transfer			
		2-Mailed 4-Phone 6-CD/disk			

III. Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone		
*Street Address			City		
County		State/Country		*ZIP Code	
Facility Type		<u>Outpatient:</u>		<u>Screening, Diagnostic, Referral Agency:</u>	
<u>Inpatient:</u>		Private physician's office		Emergency room	
Hospital		Adult HIV clinic		Laboratory	
Other, specify		Other, specify		Corrections	
				Unknown	
				Other, specify	
Date Form Completed		*Person Completing Form		*Phone	
/ /					

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

Sex Assigned at Birth		Male Female Unknown	
Country of Birth		Date of Birth	
US		/ /	
Other/US dependency (specify)		Alias Date of Birth	
		/ /	
Vital Status		Date of Death	
1-Alive 2-Dead		/ /	
		State of Death	

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

Gender Identity			Date Identified ____/____/____
Man			
Woman	Additional gender identity (specify) _____		
Transgender man	Declined to answer		
Transgender woman	Unknown		
Sexual Orientation			Date Identified ____/____/____
Straight or heterosexual	Declined to answer		
Lesbian or gay	Unknown		
Bisexual			
Additional sexual orientation (specify) _____			
Ethnicity	Hispanic/Latino	Not Hispanic/Latino	Unknown
			Expanded Ethnicity _____
Race (check all that apply)	American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander	
	Asian	White	
	Black/African American	Unknown	
			Expanded Race _____

V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below)			
Residence at HIV diagnosis		Residence at stage 3 (AIDS) diagnosis	Check if <u>SAME</u> as current address
Address Type	*Street Address		
Residential	Military		
Bad address	Other		
Correctional facility	Postal	City	County
Foster home	Shelter		
Homeless	Temporary	State/Country	*ZIP Code

VI. Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below)		HIV	Stage 3 (AIDS)	Check if <u>SAME</u> as facility providing information
Facility Name			*Phone	
*Street Address			City	
County			*ZIP Code	
Facility Type	<u>Outpatient:</u>	<u>Screening, Diagnostic, Referral Agency:</u>	<u>Other Facility:</u>	
<u>Inpatient:</u>	Private physician's office	CTS	Emergency room	
Hospital	Adult HIV clinic	STD clinic	Laboratory	
Other, specify	Other, specify	Other, specify	Corrections	
			Unknown	
			Other, specify	
*Provider Name		*Provider Phone	Specialty	

VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Pediatric Risk (enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:			
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	Yes	No	Unknown
Specify clotting factor: _____	Date received ____/____/____		

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, 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).

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

HETEROSEXUAL relations with any of the following:			
HETEROSEXUAL contact with person who injected drugs	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 (include detail in Comments)	Yes	No	Unknown

VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Acute HIV Infection

Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result 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 ____ / ____ / ____	Yes	No	Unknown
Other evidence suggestive of acute HIV infection? If YES, describe: _____ Date of evidence ____ / ____ / ____	Yes	No	Unknown

Opportunistic Illnesses

Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Lymphoma, Burkitt's (or equivalent)	
Candidiasis, esophageal		Lymphoma, immunoblastic (or equivalent)	
Carcinoma, invasive cervical		Lymphoma, primary in brain	
Coccidioidomycosis, disseminated or extrapulmonary		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Cryptococcosis, extrapulmonary		M. tuberculosis, pulmonary ¹	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		M. tuberculosis, disseminated or extrapulmonary ¹	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Cytomegalovirus retinitis (with loss of vision)		Pneumocystis pneumonia	
HIV encephalopathy		Pneumonia, recurrent, in 12 mo. period	
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		Progressive multifocal leukoencephalopathy	
Histoplasmosis, disseminated or extrapulmonary		Salmonella septicemia, recurrent	
Isosporiasis, chronic intestinal (>1 mo. duration)		Toxoplasmosis of brain, onset at >1 mo. of age	
Kaposi's sarcoma		Wasting syndrome due to HIV	

¹If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: _____

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays	TEST	HIV-1 IA	HIV-1/2 IA	HIV-1/2 Ag/Ab	HIV-2 IA
Test Brand Name/Manufacturer					Lab Name
Facility Name					Provider Name
Result	Collection Date	Testing Option (if applicable)			
Positive	____ / ____ / ____	Point-of-care test by provider			
Negative		Self-test, result directly observed by a provider ²			
Indeterminate		Lab test, self-collected sample			

TEST		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	Analyte results:			Collection Date	Testing Option (if applicable)
Overall:	HIV-1 Ag:	HIV-1/2 Ab:			Point-of-care test by provider
Reactive	Reactive	Reactive	/	/	Self-test, result directly observed by a provider ²
Nonreactive	Nonreactive	Nonreactive			Lab test, self-collected sample

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		Lab Name			
Facility Name		Provider Name			
Result³	Analyte results:			Collection Date	
Overall interpretation:	HIV-1 Ag:	HIV-1 Ab:	HIV-2 Ab:		
Reactive	Reactive	Reactive	Reactive	/	/
Nonreactive	Nonreactive	Nonreactive	Nonreactive		
Index Value	Not reportable due to high Ab level	Reactive undifferentiated	Reactive undifferentiated		Testing Option (if applicable)
	Index Value	Index Value	Index Value		Point-of-care test by provider
					Self-test, result directly observed by a provider ²
					Lab test, self-collected sample

TEST		HIV-1/2 type differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)			
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Result⁴		Analyte results:		Collection Date	
Overall interpretation:		HIV-1 Ab:	HIV-2 Ab:		
HIV positive, untypable	HIV indeterminate	Positive	Positive	/	/
HIV-1 positive with HIV-2 cross-reactivity	HIV-1 indeterminate	Negative	Negative		
HIV-2 positive with HIV-1 cross-reactivity	HIV-2 indeterminate	Indeterminate	Indeterminate		Testing Option (if applicable)
HIV negative	HIV-1 positive				Point-of-care test by provider
	HIV-2 positive				Self-test, result directly observed by a provider ²
					Lab test, self-collected sample

TEST		HIV-1 WB	HIV-1 IFA	HIV-2 WB
Test Brand Name/Manufacturer		Lab Name		
Facility Name		Provider Name		
Result		Collection Date	Testing Option (if applicable)	
Positive		/	Point-of-care test by provider	
Negative			Self-test, result directly observed by a provider ²	
Indeterminate			Lab test, self-collected sample	

TEST		HIV-1/2 RNA NAAT (Qualitative)			
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Result		Collection Date	Testing Option (if applicable)		
HIV-1	HIV, not differentiated (HIV-1 or HIV-2)	/	Point-of-care test by provider		
HIV-2	Neither (negative)		Self-test, result directly observed by a provider ²		
Both (HIV-1 and HIV-2)			Lab test, self-collected sample		

TEST		HIV-1 RNA NAAT (Qualitative and Quantitative)			
Test Brand Name/Manufacturer		Lab Name			
Facility Name		Provider Name			
Result	Analyte results:	Copies/mL	Testing Option (if applicable)		
Qualitative:	HIV-1 Quantitative		Point-of-care test by provider		
Reactive	Detectable above limit	Log	Self-test, result directly observed by a provider ²		
Nonreactive	Detectable within limits		Lab test, self-collected sample		
	Detectable below limit	Collection Date			

	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 ____/____/____	Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample

	TEST	HIV-1 RNA/DNA NAAT (Quantitative)	HIV-2 RNA/DNA NAAT (Quantitative)
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	
Result Detectable above limit Detectable within limits Detectable below limit Not detected		Copies/mL ____ Log ____ Collection Date ____/____/____	Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample

Drug Resistance Tests (Genotypic)	TEST	HIV-1 Genotype (Unspecified)
Test Brand Name/Manufacturer		Lab Name
Facility Name		Provider Name
Collection Date ____/____/____		

Immunologic Tests (CD4 count and percentage)			
CD4 count ____ cells/μL	CD4 percentage ____ %	Collection Date ____/____/____	
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	

Documentation of Tests			
Complete only if none of the following were positive for HIV-1 : Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.			
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? Yes No Unknown			
If YES, provide specimen collection date of earliest positive test result for this algorithm ____/____/____			
Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? Yes No Unknown			
If YES, provide date of diagnosis by physician ____/____/____			
Date of last documented negative HIV test result (before HIV diagnosis date) ____/____/____			
Specify type of test: _____			
Testing Option (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider ² Lab test, self-collected sample			
<small>² Results not directly observed by a provider should be recorded in HIV Testing History. ³ Complete the overall interpretation and the analyte results. ⁴ Always complete the overall interpretation. Complete the analyte results when available.</small>			

X. 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 ____/____/____			
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 <u>Inpatient:</u> Hospital Other, specify _____		<u>Other Facility:</u> Emergency room Unknown Corrections Other, specify _____	
*Street Address _____		City _____	
County _____		State/Country _____	
		*ZIP Code _____	

XI. Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one)			Date patient reported information _____ / ____ / ____	Ever taken any ARVs?		
Patient interview	Provider report	Other		Yes	No	Unknown
Medical record review NHM&E						
If yes, reason for ARV use (select all that apply)						
	ARV medications		Date began _____ / ____ / ____		Date of last use _____ / ____ / ____	
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 _____ / ____ / ____	

XII. HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one)					Date patient reported information _____ / ____ / ____
Patient interview	Medical record review	Provider report	NHM&E	Other	
Ever had previous positive HIV test result?		Date of first positive HIV test result _____ / ____ / ____		Was the first positive test result from a self-test performed by the patient?	
Yes	No	Unknown			Yes No Unknown
Ever had a negative HIV test result?		Date of last negative HIV test result _____ / ____ / ____		Was the last negative test result from a self-test performed by the patient?	
Yes	No	Unknown	(if date is from a lab test with test type, enter in Lab Data section)		Yes No Unknown
Number of negative HIV test results within the 24 months before the first positive test result _____					Unknown
How many of these negative test results were from self-tests performed by the patient? _____					Unknown

XIII. Comments

XIV. *Local/Optional Fields