HIV Surveillance Program

Bureau of HIV/STI/Viral Hepatitis

Ohio Department of Health

OHIO ADULT HIV CASE REPORT FORM

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

PATIENT IDENTIFICATION

First Name:	Middle Name:	Last Name:	Alias:

Address Type: ☐ Residential ☐ Prison (State or Federal) ☐ Jail (City or County) ☐ Drug Treatment Facility ☐ Unhoused ☐ Other

Street Address:

City:	County:	State / Country:	ZIP:

Phone:	Social Security # (Last Four):	Medical Record Number:	Vital Status: ☐ Alive ☐ Dead	Date of Death:

PATIENT DEMOGRAPHICS

Date of Birth:	Sex at Birth: ☐ Male ☐ Female ☐ Unknown	Current Gender Identity (e.g., male, female, transgender, non-binary, etc.):

Country of Birth: ☐ US ☐ Other - Specify:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Race (Check all that apply): ☐ American Indian / Alaskan Native ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ Middle Eastern or North African ☐ Asian ☐ White ☐ Other ☐ Unknown

PREVIOUS POSITIVE INFORMATION (Only fill out if patient has previously tested positive for HIV)

Diagnosis Date:	State / Country of Diagnosis:	Diagnosing Facility:

LABORATORY DATA

HIV Screening Test at Diagnosis:

HIV-1/2 Screening: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

Point-of-Care Rapid HIV Test: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Confirmation / Differentation (Geenius):

HIV-1: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV-2: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Viral Load Test - Quantitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D — **Copies/ml:** — ☐ ND — **Collection Date:**

HIV Detection Tests - Qualitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

HIV-2 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

CD4 Tests:

Count:	Percent: %	Collection Date:

Resistance Tests:

Genotype Test Done? ☐ Yes ☐ No ☐ Unknown — **Collection Date:**

Other HIV Testing (Enter Any Additional HIV Tests):

Test Type:	Result:	Collection Date:

Past HIV Testing

Has this person ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown

If YES, date of the most recent negative test:

PATIENT HISTORY

Sex with person assigned male at birth.	☐ Yes ☐ No ☐ Unknown
Sex with person assigned female at birth.	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs or shared injection equipment.	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with a person who injects drugs.	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with bisexual male (for patient assigned female at birth only).	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with person living with HIV.	☐ Yes ☐ No ☐ Unknown
Other-specify:	

OPPORTUNISTIC INFECTIONS (Click here for common opportunistic infections)	
Diagnosis(es) - list all that apply:	**Diagnosis Date:**

TREATMENT HISTORY	
Has patient ever taken any antiretroviral medications (ARVs): ☐ Yes ☐ No ☐ Unknown	**If YES, date ARV's last taken:**
ARV's currently taking (list all that apply):	

FOR PREGNANT PERSONS OR PERSONS OF CHILDBEARING POTENTIAL		
Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown	**If currently pregnant, estimated date of delivery:**	**Has the patient been referred for prenatal care?** ☐ Yes ☐ No ☐ Unknown
Patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown	**If delivered, most recent delivery date:**	**Child's Name:**

Delivery Hospital:	**City:**	**State:**

FACILITY PROVIDING INFORMATION			
Facility Name:		**Street Address:**	
City:	**County:**	**State:**	**Zip Code:**
Name of Provider that Ordered HIV Diagnostic Tests:		**Specialty:**	**Phone Number:**

PERSON PROVIDING INFORMATION		
Date Form Completed:	**Person Completing Form:**	**Phone Number/Email:**

COMMENTS SECTION
Provide any additional information about the patient:

Complete and submit the case form by one of the following methods:

Fax: 614-388-9782

Mail the report form in an envelope marked "Confidential" to:

Ohio Department of Health
HIV Surveillance Program
246 N. High St
Columbus, OH 43215

If you have any questions, email **HIVsurveillance@odh.ohio.gov.**

All confirmed cases of HIV, including Stage 3 (AIDS), are required to be reported by healthcare providers and laboratories to the designated health authorities per Ohio Administrative Code 3701-3-12.