**I. STATE/LOCAL USE ONLY**

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT – *Patient identifier information is not transmitted to CDC!* –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

# ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
**(Patients ≥13 years of age at time of diagnosis)**

CDC Centers for Disease Control and Prevention

## II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

DATE FORM COMPLETED: Mo. Day Yr. ☐☐ ☐☐ ☐☐

REPORT SOURCE: ☐☐

SOUNDEX CODE: ☐☐☐☐

REPORT STATUS: 1 New Report 2 Update

REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____

State Patient No.: ☐☐☐☐☐☐☐☐☐☐

City/County Patient No.: ☐☐☐☐☐☐☐☐☐☐

## III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): 1 HIV Infection (not AIDS) 2 AIDS

AGE AT DIAGNOSIS: ☐☐ Years ☐☐ Years

DATE OF BIRTH: Mo. Day Yr. ☐☐ ☐☐ ☐☐

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Mo. Day Yr. ☐☐ ☐☐ ☐☐

STATE/TERRITORY OF DEATH: _____

SEX: 1 Male 2 Female

ETHNICITY: (select one) 1 Hispanic 9 Unk 2 Not Hispanic or Latino

RACE: (select one or more) ☐ American Indian/Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unk

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: ☐☐☐☐☐

## IV. FACILITY OF DIAGNOSIS

Facility Name _____

City _____

State/Country _____

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 88 Other (specify): _____

This report to the Centers for Disease Control and Prevention (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/AIDS. Information in CDC's HIV/AIDS 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 on file at the local health department, 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).

## V. PATIENT HISTORY

**AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD** (Respond to **ALL** Categories):

| | Yes | No | Unk. |
|---|---|---|---|
| • Sex with male | 1 | 0 | 9 |
| • Sex with female | 1 | 0 | 9 |
| • Injected nonprescription drugs | 1 | 0 | 9 |
| • Received clotting factor for hemophilia/coagulation disorder | 1 | 0 | 9 |
| Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify): _____ | | | |
| • *HETEROSEXUAL* relations with any of the following: | | | |
| • Intravenous/injection drug user | 1 | 0 | 9 |
| • Bisexual male | 1 | 0 | 9 |
| • Person with hemophilia/coagulation disorder | 1 | 0 | 9 |
| • Transfusion recipient with documented HIV infection | 1 | 0 | 9 |
| • Transplant recipient with documented HIV infection | 1 | 0 | 9 |
| • Person with AIDS or documented HIV infection, risk not specified | 1 | 0 | 9 |
| • Received transfusion of blood/blood components (other than clotting factor) | 1 | 0 | 9 |
| First Mo. ☐☐ Yr. ☐☐ Last Mo. ☐☐ Yr. ☐☐ | | | |
| • Received transplant of tissue/organs or artificial insemination | 1 | 0 | 9 |
| • Worked in a health-care or clinical laboratory setting | 1 | 0 | 9 |
| (specify occupation): _____ | | | |

## VI. LABORATORY DATA

**1. HIV ANTIBODY TESTS AT DIAGNOSIS:** (Indicate first test)

| | Pos | Neg | Ind | Not Done | TEST DATE Mo. | Yr. |
|---|---|---|---|---|---|---|
| • HIV–1 EIA | 1 | 0 | – | 9 | ☐☐ | ☐☐ |
| • HIV–1/HIV–2 combination EIA | 1 | 0 | – | 9 | ☐☐ | ☐☐ |
| • HIV–1 Western blot/IFA | 1 | 0 | 8 | 9 | ☐☐ | ☐☐ |
| • Other HIV antibody test (specify): _____ | 1 | 0 | 8 | 9 | ☐☐ | ☐☐ |

**2. POSITIVE HIV DETECTION TEST:** (Record earliest test) Mo. ☐☐ Yr. ☐☐

☐ culture ☐ antigen ☐ PCR, DNA or RNA probe

• Other (specify): _____ Mo. ☐☐ Yr. ☐☐

**3. DETECTABLE VIRAL LOAD TEST:** (Record most recent test)

Test type* ☐☐ COPIES/ML ☐,☐☐☐,☐☐☐ Mo. ☐☐ Yr. ☐☐

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

• Date of last documented negative HIV test (specify type): _____ Mo. ☐☐ Yr. ☐☐

| | Yes | No | Unk. |
|---|---|---|---|
| • If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? | 1 | 0 | 9 |

If yes, provide date of documentation by physician ..... Mo. ☐☐ Yr. ☐☐

**4. IMMUNOLOGIC LAB TESTS:**

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

| | | Mo. | Yr. |
|---|---|---|---|
| • CD4 Count | ☐,☐☐☐ cells/∝L | ☐☐ | ☐☐ |
| • CD4 Percent | ☐☐ % | ☐☐ | ☐☐ |

First <200 ∝L or <14%

| | | Mo. | Yr. |
|---|---|---|---|
| • CD4 Count | ☐,☐☐☐ cells/∝L | ☐☐ | ☐☐ |
| • CD4 Percent | ☐☐ % | ☐☐ | ☐☐ |

**VII. STATE/LOCAL USE ONLY**

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

***– Patient identifier information is not transmitted to CDC! –***

## VIII. CLINICAL STATUS

**CLINICAL RECORD REVIEWED:** Yes [1] No [0]

**ENTER DATE PATIENT WAS DIAGNOSED AS:** Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. Symptomatic (not AIDS) : Mo. Yr.

| AIDS INDICATOR DISEASES | Initial Diagnosis Def. | Initial Diagnosis Pres. | Initial Date Mo. | Initial Date Yr. |
|---|---|---|---|---|
| Candidiasis, bronchi, trachea, or lungs | [1] | NA | | |
| Candidiasis, esophageal | [1] | [2] | | |
| Carcinoma, invasive cervical | [1] | NA | | |
| Coccidioidomycosis, disseminated or extrapulmonary | [1] | NA | | |
| Cryptococcosis, extrapulmonary | [1] | NA | | |
| Cryptosporidiosis, chronic intestinal (>1 mo. duration) | [1] | NA | | |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) | [1] | NA | | |
| Cytomegalovirus retinitis (with loss of vision) | [1] | [2] | | |
| HIV encephalopathy | [1] | NA | | |
| Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis | [1] | NA | | |
| Histoplasmosis, disseminated or extrapulmonary | [1] | NA | | |
| Isosporiasis, chronic intestinal (>1 mo. duration) | [1] | NA | | |
| Kaposi's sarcoma | [1] | [2] | | |

| AIDS INDICATOR DISEASES | Initial Diagnosis Def. | Initial Diagnosis Pres. | Initial Date Mo. | Initial Date Yr. |
|---|---|---|---|---|
| Lymphoma, Burkitt's (or equivalent term) | [1] | NA | | |
| Lymphoma, immunoblastic (or equivalent term) | [1] | NA | | |
| Lymphoma, primary in brain | [1] | NA | | |
| *Mycobacterium avium* complex or *M.kansasii*, disseminated or extrapulmonary | [1] | [2] | | |
| *M. tuberculosis*, pulmonary* | [1] | [2] | | |
| *M. tuberculosis*, disseminated or extrapulmonary* | [1] | [2] | | |
| *Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary | [1] | [2] | | |
| *Pneumocystis carinii* pneumonia | [1] | [2] | | |
| Pneumonia, recurrent, in 12 mo. period | [1] | [2] | | |
| Progressive multifocal leukoencephalopathy | [1] | NA | | |
| Salmonella septicemia, recurrent | [1] | NA | | |
| Toxoplasmosis of brain | [1] | [2] | | |
| Wasting syndrome due to HIV | [1] | NA | | |

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.: _____

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

## IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

| | Yes | No | NA | Unk. |
|---|---|---|---|---|
| • HIV related medical services | [1] | [0] | – | [9] |
| • Substance abuse treatment services | [1] | [0] | [8] | [9] |

This patient received or is receiving:

| | Yes | No | Unk. |
|---|---|---|---|
| • Anti-retroviral therapy | [1] | [0] | [9] |
| • PCP prophylaxis | [1] | [0] | [9] |

This patient has been enrolled at:

| Clinical Trial | Clinic |
|---|---|
| [1] NIH-sponsored | [1] HRSA-sponsored |
| [2] Other | [2] Other |
| [3] None | [3] None |
| [9] Unknown | [9] Unknown |

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

**FOR WOMEN:**
- This patient is receiving or has been referred for gynecological or obstetrical services: [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

**CHILD'S DATE OF BIRTH:** Mo. Day Yr.

Hospital of Birth: _____
City: _____ State: _____

**Child's Soundex:**

**Child's State Patient No.**

## X. COMMENTS: _____