### ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

#### II. HEALTH DEPARTMENT USE ONLY

- **DATE FORM COMPLETED:**
  - Mo: [ ]
  - Day: [ ]
  - Yr: [ ]

- **REPORT SOURCE:**
  - [ ]

- **SOUND CODE:**
  - [ ]

- **REPORT STATUS:**
  - [ ] New Report
  - [ ] Update

- **REPORTING HEALTH DEPARTMENT:**
  - State: [ ]
  - City: [ ]
  - County: [ ]

#### III. DEMOGRAPHIC INFORMATION

- **DIAGNOSTIC STATUS AT REPORT (check one):**
  - [ ] HIV Infection (not AIDS)
  - [ ] AIDS

- **AGE AT DIAGNOSIS:**
  - [ ] Years

- **SEX:**
  - [ ] Male
  - [ ] Female

- **ETHNICITY (select one):**
  - [ ] Hispanic
  - [ ] Black or African American
  - [ ] American Indian/Alaska Native
  - [ ] Asian
  - [ ] Native Hawaiian or Other Pacific Islander
  - [ ] White

- **RESIDENCE AT DIAGNOSIS:**
  - City: [ ]
  - County: [ ]

- **COUNTRY OF BIRTH:**
  - [ ] U.S.
  - [ ] U.S. Dependencies and Possessions
  - [ ] Other (specify): [ ]

- **CITY/STATE:**
  - City: [ ]
  - State: [ ]
  - County: [ ]

- **DATE OF BIRTH:**
  - Mo: [ ]
  - Day: [ ]
  - Yr: [ ]

- **CURRENT STATUS:**
  - Alive: [ ]
  - Dead: [ ]
  - Unk: [ ]

- **DATE OF DEATH:**
  - Mo: [ ]
  - Day: [ ]
  - Yr: [ ]

- **STATE/TERRITORY OF DEATH:**
  - [ ]

#### IV. FACILITY OF DIAGNOSIS

- **Facility Name:**
  - [ ]

- **City:**
  - [ ]

- **State/Country:**
  - [ ]

- **FACILITY SETTING (check one):**
  - [ ] Public
  - [ ] Private
  - [ ] Federal
  - [ ] Unk

- **FACILITY TYPE (check one):**
  - [ ] Physician, HMO
  - [ ] Hospital, Inpatient
  - [ ] Other (specify): [ ]

- **Facility Name:**
  - [ ]

- **City:**
  - [ ]

- **State/Country:**
  - [ ]

- **FACILITY SETTING (check one):**
  - [ ] Public
  - [ ] Private
  - [ ] Federal
  - [ ] Unk

- **FACILITY TYPE (check one):**
  - [ ] Physician, HMO
  - [ ] Hospital, Inpatient
  - [ ] 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 242d). 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 in CDC’s AIDS/HIV surveillance system. Information in CDC’s AIDS/HIV surveillance system 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 303(c) of the Public Health Service Act (42 USC 242m).**

#### V. PATIENT HISTORY

- **AFTER 1977 AND PRECEDES THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):**
  - Sex with male: [ ]
  - Sex with female: [ ]
  - Injected nonprescription drugs: [ ]
  - Received clotting factor for hemophilia/coagulation disorder: [ ]
  - Factor VIII: [ ]
  - Factor IX: [ ]
  - Other disorder: [ ]
  - Hemophilia A: [ ]
  - Hemophilia B: [ ]
  - HETEROSEXUAL relations with any of the following:
    - Intravenous/injection drug user: [ ]
    - Bisexual male: [ ]
    - Person with hemophilia/coagulation disorder: [ ]
    - Transfusion recipient with documented HIV infection: [ ]
    - Transplant recipient with documented HIV infection: [ ]
    - Person with AIDS or documented HIV infection, risk not specified: [ ]
    - Received transfusion of blood/blood components (other than clotting factor): [ ]
    - First: [ ]
    - Last: [ ]
    - Received transplant of tissue/organ: [ ]
    - Artificial insemination: [ ]
    - Worked in a health-care or clinical laboratory setting: [ ]

- **Specify occupation:** [ ]

#### VI. LABORATORY DATA

- **HIV ANTIBODY TESTS AT DIAGNOSIS:**
  - [ ] HIV-1 EIA
  - [ ] HIV-1/HIV-2 combination EIA
  - [ ] HIV-1 Western blot/IFA
  - [ ] Other antibody test (specify): [ ]

- **TEST DATE:**
  - Mo: [ ]
  - Yr: [ ]

- **NOT DONE:**
  - Mo: [ ]
  - Yr: [ ]

- **SITE:**
  - Mo: [ ]
  - Yr: [ ]

- **OTHER:**
  - Mo: [ ]
  - Yr: [ ]

- **DATE OF LAST DOCUMENTED NEGATIVE HIV TEST:**
  - Mo: [ ]
  - Yr: [ ]

- **If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?**
  - Yes: [ ]
  - No: [ ]
  - Unk: [ ]

- **If yes, provide date of documentation by physician:**
  - Mo: [ ]
  - Yr: [ ]

#### 4. IMMUNOLOGIC LAB TESTS:

**AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS**

- **CD4 Count:** [ ]
  - Mo: [ ]
  - Yr: [ ]
  - cells/mL

- **CD4 Percent:** [ ]
  - Mo: [ ]
  - Yr: [ ]
  - %

- **First <200 mL or <14%:** [ ]
  - Mo: [ ]
  - Yr: [ ]
  - %

- **CD4 Count:** [ ]
  - Mo: [ ]
  - Yr: [ ]
  - cells/mL

- **CD4 Percent:** [ ]
  - Mo: [ ]
  - Yr: [ ]
  - %
### VIII. CLINICAL STATUS

#### AIDS INDICATOR DISEASES

<table>
<thead>
<tr>
<th>Disease</th>
<th>Initial Diagnosis</th>
<th>Initial Date</th>
<th>Symptomatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidiasis, bronchi, trachea, or lungs</td>
<td>1 NA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Candidiasis, esophageal</td>
<td>1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carcinoma, invasive cervical</td>
<td>1 NA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Coccidioidomycosis, disseminated or extrapulmonary</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryptococcosis, extrapulmonary</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryptosporidiosis, chronic intestinal (&gt;-1 mo. duration)</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytomegalovirus disease (other than in liver, spleen, or nodes)</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytomegalovirus retinitis (with loss of vision)</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV encephalopathy</td>
<td>1 NA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Herpes simplex: chronic ulcer(s) (&gt;-1 mo. duration); or bronchitis, pneumonitis or esophagitis</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histoplasmosis, disseminated or extrapulmonary</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isosporiasis, chronic intestinal (&gt;-1 mo. duration)</td>
<td>1 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaposi's sarcoma</td>
<td>1 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### RVCT CASE NO.: [ ]

Def. = definitive diagnosis  Pres. = presumptive diagnosis

- 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 received or is receiving: 1 Anti-retroviral therapy 2 PEP prophylaxis

This patient has been enrolled at: Clinical Trial: 1 NIH-sponsored 2 Other 3 None 9 Unknown
HRSA-sponsored: 1 Other 2 None 3 None 9 Unknown

This patient is receiving or has been referred for: 1 HIV-related medical services 2 Substance abuse treatment services

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

FOR WOMEN: 1 This patient is receiving or has been referred for gynecological or obstetrical services 2 Is this patient currently pregnant? 3 Has this patient delivered live-born infants? 4 (If delivered after 1977, provide birth information below for the most recent birth)

### X. COMMENTS:

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection. Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, P.O. Box 12117, Atlanta, GA 30333, Attn: PRA 0920-0073. Do not send the completed form to this address.