Adult HIV Confidential Case Report Form

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

Mail completed form to:
Rhode Island Department of Health, Center for HIV, Hepatitis, STDs, and TB Epidemiology
Room 106A, 3 Capitol Hill, Providence, RI 02908 Tel: 401-222-2577

This section: Rhode Island Department of Health (RIDOH) use only

Date Received at RIDOH _____/_____/_____	**Surveillance Method** ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	**State Number**
Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 6-CD/Disk	**Last Name Soundex**

Patient Information Record all dates as mm/dd/yyyy.

Patient Name (First, Middle, Last)

Alternate Name Type (First, Middle, Last [ex. Alias, Married])

Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	**Current Street Address**	**Phone** ( )

City	**County**	**State/Country**	**Zip Code**

Medical Record Number	**Other ID Type (Social Security #, or other)**	**Number**

Facility Providing Information

Facility name **Phone** ( )

Street Address

City	**County**	**State/Country**	**Zip Code**

Facility Type *Inpatient*: ☐ Hospital ☐ Other _____ *Outpatient*: ☐Private physician's office ☐Adult HIV Clinic ☐Other, specify _____

Screening Diagnostic Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other, specify _____ *Other Facility*: ☐ Emergency Room ☐Laboratory ☐Corrections ☐Unknown ☐Other, specify _____

Date Form Completed _____/_____/_____	**Person Completing Form**	**Phone** ( )

Patient Demographics

Sex assigned at birth ☐ Male ☐ Female ☐ Unknown	**Country of birth** ☐ US ☐ Other / US Dependency Please specify: _____
Date of birth _____/_____/_____	**Alias date of birth** _____/_____/_____
Vital Status ☐ Alive ☐ Dead	**Date of death** _____/_____/_____ **State of death** _____

Current gender identity ☐ Male ☐ Female ☐ Transgender male-to-female (MTF) ☐ Transgender female-to-male (FTM) ☐ Unknown ☐ Additional gender identity, specify

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown **Expanded ethnicity:** _____	**Race (*check all that apply*)** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Unknown **Expanded race:** _____

Residence At Diagnosis Add additional addresses in *comments*, page 4.

Address type (*check all that apply*) ☐ Residence at HIV diagnosis ☐ Residence at Stage 3 (AIDS) diagnosis ☐ Check if SAME as current address

Street Address

City	**County**	**State/Country**	**Zip Code**

Facility of Diagnosis Add additional facilities in *Comments*, page 4.

Diagnosis type □ HIV □ Stage 3 (AIDS) □ Check if SAME as Facility Providing Information, Page 1			
Facility Name			**Phone** ( )
Street Address			
City	**County**	**State/Country**	**Zip Code**
Facility type: *Inpatient:* □ Hospital □ Other _____	*Outpatient:* □ Private physician's office □ Adult HIV Clinic □ Other, specify _____	*Screening Diagnostic Referral Agency:* □ CTS □ STD Clinic □ Other, specify _____	*Other Facility:* □ Emergency Room □ Laboratory □ Corrections □ Unknown □ Other, specify _____
Provider name	**Provider phone ( )**	**Specialty**	

Patient History Respond to all questions. □ **Pediatric risk:** If applicable, check and note in *Comments*, page 4.

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 non-prescription drugs	□ Yes □ No □ Unknown
Received clotting factor for hemophilia/ coagulation disorder — Specify clotting factor:_____ Date received (mm/dd/yyyy):____/____/_____	□ Yes □ No □ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	□ 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*, page 4.	□ 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. If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	□ Yes □ No □ Unknown
Other documented risk (Please include details in *Comments*, page 4.)	□ Yes □ No □ Unknown

Clinical (Acute HIV Infection and Opportunistic Illnesses)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*	□ Yes □ No □ Unk
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/____	□ Yes □ No □ Unk
Other evidence suggestive of acute HIV infection? *If YES, please describe*: Date of evidence ____/____/____	□ Yes □ No □ Unk

Opportunistic Illnesses

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

[1]If TB selected above, indicate RVCT Case Number:

Laboratory Data Record additional tests in *Comments*, page 4.

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ Lab name _____

Result ☐ Positive ☐ Negative ☐ Indeterminate Collection Date ____/____/____ ☐ Point-of-care rapid test

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ Lab name

Result ☐ Positive ☐ Negative ☐ Indeterminate Collection Date ____/____/____ ☐ Point-of-care rapid test

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay**
(differentiates between HIV-1 Ab and HIV-2 Ab)

Role of test in diagnostic algorithm
☐ Screening/initial test ☐ Confirmatory/supplemental test

Test brand name/Manufacturer _____ Lab name _____

Result[1] *Overall interpretation*: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative

Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate Collection Date ____/____/____ ☐ Point-of-care rapid test

HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate

[1]Always complete the overall interpretation. Complete analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)

Test brand name/Manufacturer _____ Lab name _____

Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid

Collection Date ____/____/____ ☐ Point-of-care rapid 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 _____

Result[2] *Overall interpretation*: ☐ Reactive ☐ Nonreactive ☐ Index value _____

Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level Index value _____

HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated Index value _____

HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated Index value _____

Collection Date ____/____/____ ☐ Point-of-care rapid test

[2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

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 _____

Result ☐ Positive ☐ Negative ☐ Indeterminate Collection Date ____/____/____

HIV Detection Tests (Quantitative viral load) **Note: Include earliest test at or after diagnosis.**

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ Lab name _____

Result ☐ Detectable ☐ Undetectable Copies/mL _____ Log _____ Collection Date ____/____/____

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ Lab name _____

Result ☐ Detectable ☐ Undetectable Copies/mL _____ Log _____ Collection Date ____/____/____

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) Test brand name/Manufacturer _____

Lab name _____ Collection Date ____/____/____

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/µL CD4 percentage _____% Collection Date ____/____/____

Test brand name/Manufacturer _____ Lab name _____

First CD4 result <200 cells/µL or <14%: CD4 count _____ cells/µL CD4 percentage _____% Collection Date ____/____/____

Test brand name/Manufacturer _____ Lab name _____

Other CD4 result: CD4 count _____ cells/µL CD4 percentage _____% Collection Date ____/____/____

Test brand name/Manufacturer _____ Lab name _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown

If YES, provide specimen collection date of earliest positive test for this algorithm ____/____/____

Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown

If YES, provide date of diagnosis ____/____/____

Date of last documented negative HIV test ____/____/____ (before HIV diagnosis date)	Type of test:	Provider

Treatment/Services Referrals

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

For female patients

This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown If YES, provider name: _____	Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown If YES, due date: ___/___/_____	Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown

For children of patient: Record most recent birth in the fields below. Record additional or multiple births in *Comments* below.

Child's Name		Child's Date of Birth ___/___/_____
Child's Last Name Soundex	Child's State Number	
Facility of Birth (if child was born at home, enter "home birth" for hospital name)		Phone ( )
Street Address		
City	**County**	**State/Country** **Zip Code**

Antiretroviral Use History

Main source of antiretroviral (ARV) use information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other	Date patient reported information ___/___/_____
Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown	

If yes, reason for ARV use (select all that apply)

☐ 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 ___/___/___

HIV Testing History

Main source of testing history information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other	Date patient reported information ___/___/_____
Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown	Date of first positive HIV test ___/___/_____
Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown	Date of last negative HIV test *(if date is from a lab test with known test type, enter in Lab Data section)* ___/___/_____
Number of negative HIV tests within the 24 months before the first positive test_____ ☐ Unknown	

Comments

Optional Fields This patient is also diagnosed with:

Syphilis	☐ Yes	☐ No	☐ Unknown	Date___/___/_____
Hepatitis B	☐ Yes	☐ No	☐ Unknown	Date___/___/_____
Hepatitis C	☐ Yes	☐ No	☐ Unknown	Date___/___/_____

~ This form was adapted from CDC Form 50.42A Rev.02/2018 ~