

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	Shelter			
Bad address	Foster home	Military	Postal	Temporary			
*Current Address, Street						Address Date	
_____/_____/_____						_____/_____/_____	
*Phone		City		County		State/Country	
_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	
*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		Outpatient:		Screening, Diagnostic, Referral Agency:	
Inpatient:		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		Male Female Unknown/Undetermined			
_____/_____/_____		_____/_____/_____			
Country of Birth			Date of Birth		
US			_____/_____/_____		
Other/US dependency (specify)			_____/_____/_____		
_____/_____/_____			_____/_____/_____		
Vital Status		Date of Death		State of Death	
1-Alive 2-Dead		_____/_____/_____		_____/_____/_____	

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.**

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	Expanded Race
	Asian	White	_____
	Black/African American	Unknown	_____

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	City	County
Correctional facility	Postal	_____	_____
Foster home	Shelter	State/Country	*ZIP Code
Homeless	Temporary	_____	_____

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	State/Country	*ZIP Code	
_____	_____	_____	
Facility Type	Outpatient:	Screening, Diagnostic, Referral Agency:	Other Facility:
Inpatient:	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/identified 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 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			
<i>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.</i>			
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>Other Facility:</u>	
<u>Inpatient:</u> Hospital Other, specify		<u>Outpatient:</u> Other, specify	
		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	____		____/____/____		____/____/____	
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?					Was the first positive test result from a self-test performed by the patient?
Yes	No	Unknown			Date of first positive HIV test result
					____/____/____
					Yes
					No
					Unknown
Ever had a negative HIV test result?					Was the last negative test result from a self-test performed by the patient?
Yes	No	Unknown			Date of last negative HIV test result
					____/____/____
					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