ADULT HIV/AIDS CASE REPORT FORM
(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Information

(Record All Dates as mm/dd/yyyy) ***Shaded Fields are Required.***

Name of Person Completing Form:	Person's Phone Number: ( )	STATENO:	CITYNO:
Date Form Completed: _____/_____/_____	Reporting Health Department - City/County:	Document Source:	
Report Status: ☐ 1- New ☐ 2- Update	Physician's Name:	Physician's Phone Number: ( )	Hospital/Facility Name:
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Surveillance Method: ☐ Active ☐ Passive ☐ Follow Up ☐ Reabstraction ☐ Unknown	Report Medium: ☐ 1- Field Visit ☐ 2- Mailed ☐ 3- Phone ☐ 4- Electronic Transfer ☐ 5- CD/Disk	

II. Patient Identification

Patient Last Name:	Middle Name:	First Name:		
Alternate Name Type *(e.g. Alias, Married, etc.)*:	Last Name:	Middle Name:	First Name:	
Address Type: ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary				
Current Street Address:	City:	County:		
State/Country:	ZIP Code:	Phone Number: ( )	Social Security Number:	Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:		

III. Patient Demographics *(See Appendix 2.0 for Further Details)* *(Record All Dates as mm/dd/yyyy)*

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other/U.S. Dependency *(please specify)*: _____	Date of Birth: _____/_____/_____		
Alias Date of Birth: _____/_____/_____	Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: _____/_____/_____	State of Death:	Status: ☐ HIV ☐ AIDS

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male-to-Female (MTF) ☐ Transgender: Female-to-Male (FTM) ☐ Unknown ☐ Other Gender Identity *(specify)*: _____

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

Expanded Ethnicity:

Expanded Race:

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander
☐ Chinese ☐ Vietnamese ☐ Hawaiian
☐ Japanese ☐ Asian Indian ☐ Guamanian
☐ Filipino ☐ Laotian ☐ Samoan
☐ Korean ☐ Cambodian
☐ Other *(specify)*: _____

IV. Residence at Diagnosis *(See Appendix 3.0 for Further Details - Add Additional Addresses in Comments and Local/Optional Fields Section)* *(Required as Appropriate Based on Status)*

Address Type *(check all that apply)*: ☐ Residence at HIV Diagnosis ☐ Residence at AIDS Diagnosis ☐ Check if SAME as Current Address

	Street Address:	City:	County:	State/Country:	ZIP Code:
Address of Residence at HIV Diagnosis					
Address of Residence at AIDS Diagnosis					

V. Facility at Diagnosis *(See Appendix 4.0 for Further Details - Add Additional Facilities in Comments and Local/Optional Fields Section)* STATENO:_____

Diagnosis Type *(check all that apply to facility):* ☐ HIV Diagnosis ☐ AIDS Diagnosis ☐ Check if SAME as Facility Providing Information

Facility Name:	Phone Number: ( )	Street Address:	City:

County:	State/Country:	ZIP Code:	Provider Name:

Facility Type:

Inpatient: ☐ Hospital ☐ Other *(specify):* _____

Outpatient: ☐ Private Physician ☐ Adult HIV Clinic ☐ Other *(specify):* _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other *(specify):* _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other *(specify):* _____

VI. Patient History *(See Appendix 5.0 for Further Details - Respond to All Questions)*

☐ **Pediatric Risk** *(Please Enter in Comments and Local/Optional Fields Section)*

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with a male: ☐ Yes ☐ No ☐ Unknown Sex with a female: ☐ Yes ☐ No ☐ Unknown Injected non-prescription drugs: ☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL relations with any of the following:	**Has the patient:**
Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown	Received clotting factor for hemophilia/coagulation disorder: ☐ Yes ☐ No ☐ Unknown
Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown	Received transfusion of blood/blood components *(non-clotting)*: ☐ Yes ☐ No ☐ Unknown
Contact with a person with AIDS or documented HIV infection, risk not specified: ☐ Yes ☐ No ☐ Unknown	Other documented risk: *(if yes, specify):* ☐ Yes ☐ No ☐ Unknown
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	_____
Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	

VII. Laboratory Data *(Record All Dates as mm/dd/yyyy) (See Instructions for Details)*

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]

TEST 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST 3: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]

TEST: ☐ HIV-1/2 Differentiating *(e.g. Multispot)*

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both *(undifferentiated)* ☐ Neither *(negative)* **Collection Date**: ____/____/_____

VII. Laboratory Data *(continued)* *(Record All Dates as mm/dd/yyyy)*

STATENO:_____

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

HIV Detection Tests (Quantitative Viral Load) ***Note: Include earliest test after diagnosis***

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

Immunologic Tests (CD4 Count and Percentage)

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

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

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

Documentation of Tests *(Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA])*

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

If yes, provide date *(specimen collection date if known)* of earliest positive test for this algorithm: ____/____/_____

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

If yes, provide date of documentation by physician: ____/____/_____

VIII. Clinical *(Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)*

	✓	Date		✓	Date
Candidiasis, esophageal			Kaposi's sarcoma		
Cryptococcosis, extrapulmonary			Pneumocystis carinii pneumonia		
Cytomegalovirus disease (other than in liver, spleen or nodes)			Wasting syndrome due to HIV		
Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis			Other *(specify)*:		

IX. Treatment/Services Referrals *(Record All Dates as mm/dd/yyyy)*

Has This Patient Been Informed of His/Her HIV Infection? ☐ Yes ☐ No ☐ Unknown

Patient's Medical Treatment is Primarily Reimbursed by:

☐ 1- Medicaid ☐ 2- Private Insurance/HMO ☐ 3- No Coverage ☐ 4- Other Public Funding ☐ 9- Unknown

For Female Patient:

Is This Patient Currently Pregnant? ☐ Yes ☐ No ☐ Unknown

Has This Patient Delivered Live-Born Infants? ☐ Yes ☐ No ☐ Unknown

IX. Treatment/Services Referrals *(continued)* *(Record All Dates as mm/dd/yyyy)*

STATENO:_____

For Children of Patient: *(Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)*		
Child's Name:	Child's Soundex:	Child's Date of Birth: _____/_____/_____
Child's Coded ID:	Child's STATENO:	
Hospital of Birth: *(If Child Was Born at Home, Enter "Home Birth" for Hospital Name)*		
Hospital Name:		Phone Number: ( )
Street Address:	City:	
County:	State/Country:	ZIP Code:

X. HIV Testing and Antiretroviral Use History (TTH) *(Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)*

Main Source of Testing and Treatment History Information *(select one):* ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other *(specify):* _____			Date Patient Reported Information: _____/_____/_____
Ever Had a Positive HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of First Positive HIV Test: _____/_____/_____	Ever Had a Negative HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of Last Negative HIV Test: *(If date is from a lab test with test type, enter in Laboratory Data Section.)* _____/_____/_____
Number of Negative HIV Tests Within 24 Months Before First Positive Test *(#)*: _____ ☐ Refused ☐ Don't Know/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: _____/_____/_____	Date ARVs Last Taken *(mm/dd/yyyy):* _____/_____/_____		

XI. Duplicate Review (Office use)

Status *(check one)*: ☐ Same As ☐ Different Than ☐ Pending	State Name:	STATENO:

XII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by:_____ Entered by:_____ Entry Date:_____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

Sacramento County Department of Health Services
Sexual Health Promotion Unit
9616 Micron Ave STE 930
Sacramento, CA 95827

TO REPORT THROUGH FAX, PLEASE FAX (916) 854-9615

TO REPORT THROUGH PHONE, PLEASE CALL (916) 874-2738.