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)

II. HEALTH DEPARTMENT USE ONLY

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): _____

OTHER ETHNICITY:
Does the patient consider him / herself Arabic?
Yes No Unknown (Circle your answer)

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. ☐☐

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 No 0 Unk. 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/μL	☐☐	☐☐
• CD4 Percent	☐☐ %	☐☐	☐☐

First <200 μL or <14%

		Mo.	Yr.
• CD4 Count	☐,☐☐☐ cells/μL	☐☐	☐☐
• 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.
MI law requires physician to notify known partners or requests help from local health departments.
This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider

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: _____