

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥ 13 years of age at time of diagnosis)

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

Patient's name (last, first, MI) Telephone number Social Security Number

Address (number, street) City County State CA Zip code

II. Health Department Use Only
Date form completed Report status Report source Reporting health department State patient number City/county patient number
Soundex code Date of birth Gender CLIA number Lab report/Accession number Confidential C&T number

III. Demographic Information
Diagnosis status at report (check one) Age at Diagnosis Years Current status Date of death State/Territory of death
Country of birth
ETHNICITY RACE
Expanded race (specify):
Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country:
Residence at first diagnosis of HIV or AIDS: Homeless (Must use city/county/Zip code of local health department (LHD) or facility of diagnosis.)
City County State/Country Zip code

IV. Facility of Diagnosis (LHDs use approved abbreviations from "Facility List.")
Facility Name City State/Country
Facility setting (check one) Facility type (check one)

V. Patient Risk History (Check all that apply.)
Sex with a male/female
Injected nonprescription drugs
HETEROSEXUAL relations with any of the following:
Intravenous/injection drug users
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 clotting factor for hemophilia/coagulation disorder
Received transfusion of blood/components (other than clotting factor)
Received transplant of tissue/organs or artificial insemination
Worked in a health care or clinic laboratory setting
Perinatally-acquired HIV infection regardless of year of birth
Other (specify):

VI. Laboratory Data (Indicate first documented test(s).)
A. HIV Antibody Test at Initial HIV/AIDS Diagnosis
B. Positive HIV Detection Test (Record earlier test.)
C. HIV Viral Load Test (Record earliest test.)
D. Immunologic Lab Tests - At or closest to current diagnostic status

VII. Provider Information

Physician's name (last, first, MI)				Physician's telephone number	Patient's/Inmate's medical record number
Address (number, street)	City	State CA	Zip code	Person completing form	Telephone number

VIII. Clinical Status

Clinical record reviewed Yes No
 Enter date patient was diagnosed as: _____ Month _____ Day _____ Year _____
 • Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy).....
 • Symptomatic (not AIDS).....

AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date		AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date	
	Def.	Pres.	Month	Year		Def.	Pres.	Month	Year
Candidiasis, bronchi, trachea, or lungs	1	NA			Lymphoma, Burkitt's (or equivalent term)	1	NA		
Candidiasis, esophageal	1	2			Lymphoma, Immunoblastic (or equivalent term)	1	NA		
Carcinoma, invasive cervical	1	NA			Lymphoma, primary in brain	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA			Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1	2		
Cryptococcosis, extrapulmonary	1	NA			M. tuberculosis, pulmonary*	1	2		
Cryptosporidiosis, chronic intestinal (>1 month duration)	1	NA			M. tuberculosis, disseminated or extrapulmonary*	1	2		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1	2		
Cytomegalovirus retinitis (with loss of vision)	1	2			Pneumocystis jiroveci pneumonia (PCP)	1	2		
HIV encephalopathy	1	NA			Pneumonia, recurrent, in 12-month period	1	2		
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis	1	NA			Progressive multifocal leukoencephalopathy	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA			Salmonella septicemia, recurrent	1	NA		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA			Toxoplasmosis of brain	1	2		
Kaposi's sarcoma	1	2			Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis *RVCT case number: _____

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? Yes No Unknown

IX. Treatment/Services Referrals

Has the patient been informed of his/her HIV infection?..... Yes No Unknown
 This patient's partner(s) has been or will be notified about their HIV exposure and counseled by:
 Health Department Physician/Provider Patient Unknown
 The patient is receiving or has been referred for:
 • HIV-related medical services..... Yes No NA Unknown
 • Substance abuse treatment services..... Yes No NA Unknown
 This patient receiving or is receiving:
 • Antiretroviral Therapy..... Yes No Unknown
 • PCP prophylaxis..... Yes No Unknown
 This patient has been enrolled at:
 Clinical Trial: NIH-sponsored Other None Unknown
 Clinic: NIH-sponsored Other None Unknown
 This patient's medical treatment is primarily reimbursed by:
 Medicaid Private insurance/HMO No coverage Other public funding Clinical trial/government program Unknown

For women: • This patient is receiving or has been referred for gynecological or obstetrical services..... Yes No Unknown
 • This patient is currently pregnant..... Yes No Unknown
 • This patient has delivered live born infant(s)..... Yes No Unknown
 (If yes, provide birth information below for the most recent birth.)

Child's date of birth Month _____ Day _____ Year _____	Hospital of birth City _____ State CA	Child's Soundex _____	Health Department Use Only Child's state patient number _____
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X. HIV Incidence

Has the patient ever tested for HIV? Yes No (if this is first ever HIV test); Unknown Refused
 If yes, date of last negative _____ (MM/DD/YYYY)
 If yes, how many times did the patient test for HIV in the 2 years before the FIRST positive test?
 _____ times tested negative+1 positive test = _____ total number of tests;
 _____ Unknown; _____ Refused;
 Did the patient take any antiretrovirals (to treat, HBV, HIV, for recreational use or for any other reason) _____ months before the first positive test?
 Yes; No; Unknown; Refused
 If yes, name of medications taken _____

XI. Patient's street address at time of diagnosis:

XII. First lab test result on or after 4/17/2006:

Any Viral Load: Date: _____ Result: _____
 Copies/mL Log; Test Type: _____
 Positive WB/IF: Date: _____

XII. Comments

Start date (MM/DD/YYYY): _____ End date (MM/DD/YYYY): _____

 Assigned to: _____ Reviewed by: _____ Entered by: _____