

ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Use (Record All Dates as mm/dd/yyyy)

*** Required Sections/Fields.**

*Name of Person Completing Form:	*Person's Phone Number: ()	*STATENO:	CITYNO:
*Date Form Completed: ____/____/____	*Reporting Health Department - City/County:		*Document Source:
Physician's Name:	Physician's Phone Number: ()	Hospital/Facility Name:	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Surveillance Method: <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow Up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	Report Medium: <input type="checkbox"/> 1- Field Visit <input type="checkbox"/> 2- Mailed <input type="checkbox"/> 3- Phone <input type="checkbox"/> 4- Electronic Transfer <input type="checkbox"/> 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: <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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 (Record All Dates as mm/dd/yyyy)

*Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Country of Birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other/U.S. Dependency (please specify): _____	*Date of Birth: ____/____/____
Alias Date of Birth: ____/____/____	*Vital Status: <input type="checkbox"/> 1- Alive <input type="checkbox"/> 2- Dead	Date of Death: ____/____/____
State of Death:		*Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS
Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender: Male-to-Female (MTF) <input type="checkbox"/> Transgender: Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional Gender Identity (specify): _____		*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Cambodian <input type="checkbox"/> Other (specify): _____
*Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	Expanded Ethnicity:	
Expanded Race:		

IV. *Residence at Diagnosis (Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)

Address Type (check all that apply): <input type="checkbox"/> Residence at HIV Diagnosis <input type="checkbox"/> Residence at AIDS Diagnosis <input type="checkbox"/> Check if SAME as Current Address				
Address of Residence at HIV Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:
Address of Residence at AIDS Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:

V. *Facility at Diagnosis (Add Additional Facilities in Comments and Local/Optional Fields Section) **STATENO:** _____ **MEDREC# / ID:** _____

Diagnosis Type (check all that apply to facility): <input type="checkbox"/> HIV Diagnosis <input type="checkbox"/> AIDS Diagnosis <input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name:	Phone Number: ()	Street Address:	City:
County:	State/Country:	ZIP Code:	Provider Name:
Facility Type:	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		
	<i>Outpatient:</i> <input type="checkbox"/> Private Physician <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		

VI. *Patient History (Respond to All Questions)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with a male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Sex with a female: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
HETEROSEXUAL relations with any of the following:	Has the patient:
Contact with intravenous/injection drug user (IDU): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received clotting factor for hemophilia/coagulation disorder: Date Received: ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact with a bisexual male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received transfusion of blood/blood components (non-clotting): Date Received: ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact with a person with AIDS or documented HIV infection, risk not specified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Perinatally infected (please enter in comments and local/optional fields section): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact with transplant recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other documented risk (if yes, specify): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact with transfusion recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____

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

HIV Immunoassays (Non-differentiating)	
TEST: <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB	
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-Reactive <input type="checkbox"/> Indeterminate	
Manufacturer: _____	Rapid Test (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____
HIV Immunoassays (Differentiating)	
TEST: <input type="checkbox"/> HIV-1/2 Ag/Ab Differentiating (Differentiates between HIV Ag and HIV Ab) (e.g. Determined by Alere)	
RESULT: <input type="checkbox"/> HIV Ag <input type="checkbox"/> HIV Ab <input type="checkbox"/> Both (Ag and Ab Reactive) <input type="checkbox"/> Neither (Negative) <input type="checkbox"/> Invalid/Indeterminate	
Manufacturer: _____	Rapid Test (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____
TEST: <input type="checkbox"/> HIV-1/2 Ag/Ab and Type-Differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab) (e.g. Bio-Rad BioPlex "5th Generation")	
RESULT: COMPLETE THE OVERALL INTERPRETATION AND ANALYTE RESULTS	
Overall Interpretation: <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive Index Value: _____	
Analyte Results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Not reportable due to high HIV Ab level Index Value: _____	
HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive Undifferentiated Index Value: _____	
HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive Undifferentiated Index Value: _____	
Manufacturer: _____	Collection Date: ____/____/____
TEST: <input type="checkbox"/> HIV-1/2 Type-Differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab) (e.g. Multispot, Geenius)	
Role of test in diagnostic algorithm: <input type="checkbox"/> Initial <input type="checkbox"/> Supplemental	
RESULT: ALWAYS COMPLETE THE OVERALL INTERPRETATION. COMPLETE THE ANALYTE RESULTS WHEN AVAILABLE.	
Overall Interpretation: <input type="checkbox"/> HIV-1 Positive <input type="checkbox"/> HIV-2 Positive <input type="checkbox"/> HIV Positive, Untypable <input type="checkbox"/> HIV-2 Positive with HIV-1 Cross-Reactivity	
<input type="checkbox"/> HIV-1 Indeterminate <input type="checkbox"/> HIV-2 Indeterminate <input type="checkbox"/> HIV Indeterminate <input type="checkbox"/> HIV Negative	
Analyte Results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
Manufacturer: _____	Rapid Test (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____

HIV Detection Tests (Qualitative)	
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____
TEST 2:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____
HIV Detection Tests (Quantitative Viral Load) <i>Note: Include earliest test after diagnosis</i>	
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____
TEST 2:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____
Drug Resistance Tests (Genotypic)	
TEST:	<input type="checkbox"/> HIV-1 Genotype (Unspecified) Collection Date: ____/____/____
Immunologic Tests (CD4 Count and Percentage)	
CD4 at or closest to current diagnosis status:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____
First CD4 result <200 cells/ μ L or <14%:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____
Other CD4 result <200 cells/ μ L or <14%:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____
Documentation of Tests (Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA])	
Did documented laboratory test results meet approved HIV diagnostic algorithm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, provide date of documentation by physician: ____/____/____	
Date of last documented negative HIV test (before HIV diagnosis date): ____/____/____ Specify type of test: _____	

VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (Record All Dates as mm/dd/yyyy)

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.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? If YES, provide date of sign/symptom onset: ____/____/____		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other evidence suggestive of acute HIV infection? If YES, please describe: _____ Date of evidence: ____/____/____		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
OPPORTUNISTIC ILLNESSES		
	Dx Date	Dx 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
Coccidioidomycosis, 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 a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:		

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

STATENO: _____ MEDREC# / ID: _____

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Patient's medical treatment is primarily reimbursed by: <input type="checkbox"/> 1-Medicaid <input type="checkbox"/> 2-Private Insurance/HMO <input type="checkbox"/> 3-No Coverage <input type="checkbox"/> 4-Other Public Funding <input type="checkbox"/> 9-Unknown				
This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> 1-Health Dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown				
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) <input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 2-Yes, client self-report, only Date of medical visit or prescription ____/____/____				
FOR FEMALE PATIENTS	This patient is receiving or has been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Is This Patient Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Has This Patient Delivered Live-Born Infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
For Children of Patient: (Record Most Recent Birth Below; Record Additional or Multiple Births in Comments Section)				
Child's Name:	Child's Soundex:	Child's Date of Birth: ____/____/____	Child's Coded ID:	Child's STATENO:
Hospital Name of Birth: (If Child was born at Home, Enter "Home Birth" for Hospital Name)		County:	Phone Number: ()	
Street Address:	City:	State/Country:	Zip Code:	

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

Main Source of Testing History Information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____		Date Patient Reported Information: ____/____/____
Ever Taken Any Antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If Yes, Reason for ARV use (select all that apply):		
<input type="checkbox"/> HIV Tx	ARV med: _____	Date began: ____/____/____ Date of last use: ____/____/____
<input type="checkbox"/> PrEP	ARV med: _____	Date began: ____/____/____ Date of last use: ____/____/____
<input type="checkbox"/> PEP	ARV med: _____	Date began: ____/____/____ Date of last use: ____/____/____
<input type="checkbox"/> PMTCT	ARV med: _____	Date began: ____/____/____ Date of last use: ____/____/____
<input type="checkbox"/> HBV Tx	ARV med: _____	Date began: ____/____/____ Date of last use: ____/____/____
<input type="checkbox"/> Other:	_____	ARV med: _____ Date began: ____/____/____ Date of last use: ____/____/____

XI. *HIV Testing History (Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)

Main Source of Testing History Information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____		Date Patient Reported Information: ____/____/____	
Ever Had a Positive HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of First Positive HIV Test: ____/____/____	Ever Had a Negative HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 (#): _____ <input type="checkbox"/> Unknown			

XII. Comments and Local/Optional Fields

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

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO:

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
 600 S. COMMONWEALTH AVE, 10TH FLOOR - SUITE 1260
 LOS ANGELES, CA 90005

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