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? ☐ 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 *(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 ☐ Chinese ☐ Vietnamese ☐ Japanese ☐ Asian Indian ☐ Filipino ☐ Laotian ☐ Korean ☐ Cambodian ☐ Pacific Islander ☐ Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)*: _____

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)*: ☐ 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 *(Add Additional Facilities in Comments and Local/Optional Fields Section)* STATENO: _____ MEDREC# / ID: _____

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 *(Respond to All Questions)*

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	Perinatally infected *(please enter in comments and local/optional fields section)*: ☐ Yes ☐ No ☐ Unknown
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	Other documented risk *(if yes, specify)*: ☐ 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: _____ **MEDREC# / ID:** _____

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: _____ **MEDREC# / ID:** _____

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

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

TO DOWNLOAD THIS FORM, GO TO HTTP://PUBLICHEALTH.LACOUNTY.GOV/DHSP/REPORTCASE.HTM

TO REPORT THROUGH PHONE, PLEASE CALL (213) 351-8516.

DO NOT SEND THE REPORT BY EMAIL OR FAX.