Attachment C. Adult HIV/AIDS Confidential Case Report Form

Form name: Adult HIV/AIDS Confidential Case Report Form (CDC 50.42A)
Status: Currently in use
Proposed revision: Blank space at the top and bottom. Note that the burden statement will also be updated to indicate 20 minutes and correct MS number as stated below:

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-XXXX). **Do not send completed form to this address.**

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)

CDC — Centers for Disease Control and Prevention

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

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): _____

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

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): _____

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.

	Yes	No	Unk.
• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?	1	0	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]		
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.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

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: _____