

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)



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

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: (including Puerto Rico)
 1 U.S. 7 U.S. Dependencies and Possessions (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	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sex with female	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Injected nonprescription drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Specify <input type="checkbox"/> 1 Factor VIII <input type="checkbox"/> 2 Factor IX <input type="checkbox"/> 8 Other disorder: (Hemophilia A) (Hemophilia B) (specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Bisexual male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transfusion recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transplant recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
First Mo. Yr. <input type="text"/> <input type="text"/> Last Mo. Yr. <input type="text"/> <input type="text"/>			
• Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Worked in a health-care or clinical laboratory setting	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 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	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/>
• HIV-1/HIV-2 combination EIA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/>
• HIV-1 Western blot/IFA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/>
• Other HIV antibody test (specify): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/>

2. POSITIVE HIV DETECTION TEST: (Record earliest test)
 culture antigen PCR, DNA or RNA probe Mo. Yr.
 • Other (specify): _____ Mo. Yr.

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type*	COPIES/ML	Mo. Yr.
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

	Mo. Yr.
• CD4 Count _____ cells/μL	<input type="text"/> <input type="text"/>
• CD4 Percent _____ %	<input type="text"/> <input type="text"/>
First <200 μL or <14%	Mo. Yr. <input type="text"/> <input type="text"/>
• CD4 Count _____ cells/μL	<input type="text"/> <input type="text"/>
• CD4 Percent _____ %	<input type="text"/> <input type="text"/>

• 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? 1 Yes 0 No 9 Unk.
 If yes, provide date of documentation by physician _____ Mo. Yr.

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 <input type="checkbox"/>	No <input type="checkbox"/>	ENTER DATE PATIENT WAS DIAGNOSED AS:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Mo. <input type="checkbox"/>	Yr. <input type="checkbox"/>	Symptomatic (not AIDS):	Mo. <input type="checkbox"/>	Yr. <input type="checkbox"/>
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AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent term)	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent term)	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>
Carcinoma, invasive cervical	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, primary in brain	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycobacterium avium</i> complex or <i>M.kansasii</i> , disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis</i> , pulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis</i> , disseminated or extrapulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Pneumocystis carinii</i> pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia, recurrent, in 12 mo. period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Progressive multifocal leukoencephalopathy	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Salmonella septicemia, recurrent	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	Toxoplasmosis of brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wasting syndrome due to HIV	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>

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? Yes No Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health department <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown	This patient is receiving or has been referred for: Yes No NA Unk. • HIV related medical services <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> • Substance abuse treatment services <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
This patient received or is receiving: • Anti-retroviral therapy Yes No Unk. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • PCP prophylaxis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	This patient has been enrolled at: Clinical Trial Clinic <input type="checkbox"/> NIH-sponsored <input type="checkbox"/> HRSA-sponsored <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
This patient's medical treatment is primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private insurance/HMO <input type="checkbox"/> No coverage <input type="checkbox"/> Other Public Funding <input type="checkbox"/> Clinical trial/government program <input type="checkbox"/> Unknown	
FOR WOMEN: • 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 (if delivered after 1977, provide birth information below for the most recent birth) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
CHILD'S DATE OF BIRTH: Mo. Day Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hospital of Birth: _____ City: _____ State: _____
Child's Soundex: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Child's State Patient No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

X. COMMENTS: _____

