

Attachment 3 (a)

National HIV Surveillance System (NHSS)

OMB # 0920-0573

Adult HIV Confidential Case Report Form

Form Approved
OMB No. 0920-0573
Expiration Date XX/XX/XXXX

**Adult HIV Confidential Case Reports
For the National HIV Surveillance System (NHSS)**

Adult HIV Confidential Case Report Form

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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: PRA (0920-0573)

Patient Identification

*Patient Name	*First Name	*Middle Name	*Last Name	Last Name Soundex
*Alternate Name Type (ex Alias, Married)		*First Name	*Middle Name	*Last 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		*Phone () _____
City	County	State/Country	*ZIP Code	
*Medical Record Number		*Other ID Type: _____ Number: _____		

Adult HIV Confidential Case Report Form

(Patients ≥13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Health Department Use Only

Form approved OMB no 0920-0573 Exp. 01/31/2013

Date Received at Health Department ____/____/____	eHARS Document UID _____	State Number _____
Reporting Health Dept - City / County		City/County Number
Document Source _____	Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Report Medium <input type="checkbox"/> 1-Field Visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic Transfer <input type="checkbox"/> 6-CD/Disk	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name		*Phone () _____	
*Street Address			
City	County	State/Country	Zip Code
Facility Type	<u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<u>Outpatient:</u> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____	<u>Screening, Diagnostic, Referral</u> <u>Agency:</u> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____
		<u>Other Facility:</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
Date Form Completed ____/____/____	*Person Completing Form	*Phone () _____	

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"/> US <input type="checkbox"/> Other/ US 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 _____	
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) _____		
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	*Expanded Ethnicity _____		
Race (check all that apply)	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		*Expanded Race _____

Residence at Diagnosis (add additional addresses in Comments)

Address Type (Check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at AIDS diagnosis <input type="checkbox"/> Check if <u>SAME</u> as Current Address			
*Street Address			
City	County	State/Country	*ZIP Code

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).

Physician's Name: (Last, First, M.I.) _____

Medical Record

Phone No: () _____

No. _____

Hospital/Facility: _____

Person Completing Form: _____

Facility of Diagnosis (add additional facilities in Comments)

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

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) Pediatric risk (please enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with 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
Received clotting factor for hemophilia/ coagulation disorder	Specify clotting factor: Date received (mm/dd/yyyy): ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV Infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	
Other documented risk (please include detail in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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Laboratory Data (record additional tests in Comments section) (record all dates as mm/dd/yyyy)

HIV Antibody Tests (Non-type-differentiating) [HIV-1 vs. HIV-2]			
TEST 1:	<input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <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 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____		
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____ Manufacturer: _____		
TEST 2:	<input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <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 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____		
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____ Manufacturer: _____		
TEST 3:	<input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <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 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____		
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: ____/____/____ Manufacturer: _____		
HIV Antibody Tests (Type-differentiating) [HIV-1 vs. HIV-2]			
TEST:	<input type="checkbox"/> HIV-1/2 Differentiating (e.g., Multispot)		
RESULT:	<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Indeterminate 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) Note: Include earliest test after diagnosis			
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load)		
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)		
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____		
Immunologic Tests (CD4 count and percentage)			
CD4 at or closest to current diagnostic status:	CD4 count: _____ cells/ μ L	CD4 percentage: _____ %	Collection Date: ____/____/____
First CD4 result <200 cells/μL or <14%:	CD4 count: _____ cells/ μ L	CD4 percentage: _____ %	Collection Date: ____/____/____
Other CD4 result:	CD4 count: _____ cells/ μ L	CD4 percentage: _____ %	Collection Date: ____/____/____
Documentation of Tests			
<i>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]:</i>			
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? <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: _____			

Clinical (record all dates as mm/dd/yyyy)

		Date			Date			Date
Candidiasis, bronchi, trachea, or lungs			Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis			M. tuberculosis, pulmonary [†]		
Candidiasis, esophageal			Histoplasmosis, disseminated or extrapulmonary			M. tuberculosis, disseminated or extrapulmonary [†]		
Carcinoma, invasive cervical			Isosporiasis, chronic intestinal (>1 mo. duration)			Mycobacterium, of other/undefined 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		

[†]If TB selected above, indicate RVCT Case Number:

