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 ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ 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**

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

Health Department Use Only

Date Received at Health Department ____/____/_____	eHARS Document UID _____	State Number _____

Reporting Health Dept - City / County	City/County Number

Document Source _____	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown

Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 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	*Inpatient*: ☐ Hospital ☐ Other, specify _____	*Outpatient*: ☐ Private Physician's Office ☐ Adult HIV Clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency*: ☐ CTS ☐ STD Clinic ☐ Other, specify _____	*Other Facility*: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____

Date Form Completed ____/_____/_____	*Person Completing Form	*Phone ( ) _____

Patient Demographics (record all dates as mm/dd/yyyy)

Sex assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/ US Dependency (please specify) _____

Date of Birth ____/_____/_____	Alias Date of Birth ____/_____/_____

Vital Status ☐ 1- Alive ☐ 2- Dead	Date of Death ____/_____/_____	State of Death _____

Current Gender Identity	☐ Male ☐ Female ☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM) ☐ Unknown ☐ Additional gender identity (specify) _____

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	*Expanded Ethnicity _____

Race (check all that apply)	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown	*Expanded Race _____

Residence at Diagnosis (add additional addresses in Comments)

Address Type (Check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at AIDS diagnosis ☐ Check if SAME 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).

STATE/LOCAL USE ONLY — **– Patient identifier information is not transmitted to CDC! –**

Physician's Name: (Last, First, M.I.) _____ Phone No: ( ) _____ Medical Record No._____

Hospital/Facility: _____ Person Completing Form: _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type ☐ HIV ☐ AIDS (check all that apply to facility below) ☐ Check if SAME as Facility Providing Information

Facility Name	***Phone** ( ) _____
***Street Address**	

City	**County**	**State/Country**	**Zip Code**

Facility Type

Inpatient: ☐ Hospital ☐ Other, specify _____

Outpatient: ☐ Private Physician's Office ☐ Adult HIV Clinic ☐ Other, specify _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other, specify _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ 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	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder — Specify clotting factor: Date received (mm/dd/yyyy):____/____/_____	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV Infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section) First date received ____/____/_____ Last date received ____/____/_____	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments section)	☐ Yes ☐ No ☐ Unknown

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: ☐ 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) ☐ Indeterminate **Collection Date**: ___/____/____

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)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/____

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/____

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to current diagnostic 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: 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 criteria? ☐ 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: ____/____/____

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/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		

†If TB selected above, indicate RVCT Case Number:

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown	This patient's partners will be notified about their HIV exposure and counseled by: ☐ 1-Health Dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown	Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown	Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown

For Children of Patient (record most recent birth in these boxes; record additional or multiple births in the Comments section)

*Child's Name	Child Soundex	Child's Date of Birth
*Child's Coded ID	Child's State Number	

Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name	*Phone	*Zip Code

*Street Address	City	County	State/Country

HIV Testing and Antiretroviral Use History (if required by Health Department) (record all dates as mm/dd/yyyy)

Main source of testing and treatment history information (select one) ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other	Date patient reported information ____/____/_____

Ever had previous 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 Lab 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, ARV medications:

Dates ARVs taken Date first began: ____/____/_____ Date of last use: ____/____/_____

*Comments

*Local / Optional Fields