National HIV Surveillance System (NHSS)

Attachment 4a.

Adult HIV Confidential Case Report Form
Technical Guidance

Technical Guidance for HIV Surveillance Programs

Adult HIV Confidential Case Report Form

HIV Incidence and Case Surveillance Branch
Atlanta, Georgia

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Purpose of Case Report Form

The Adult HIV Confidential Case Report (CDC 50.42A) form (ACRF) is designed to collect information that promotes understanding of HIV infection morbidity and mortality among patients **greater than or equal to 13 years of age** at time of diagnosis. This form reflects data that are required to be collected and some that are recommended or optional. This guidance applies to all HIV infection data collection even if state or local surveillance programs use a different form or medium for HIV case surveillance. See Appendix for further guidance.

The Case Report Form in the Context of Document-Based Surveillance

Unlike case-based data management, document-based data management allows all documents to be stored and retained electronically in their original formats. Instead of completing one form for a reported case, fill out the applicable part of the form for each data source contributing information to that HIV case.

Patients for Whom Form is Indicated

- Each person, greater than or equal to 13 years of age, who meets the HIV infection or stage 3 (AIDS) case definition (available at http://wwwn.cdc.gov/nndss/conditions/hiv-infection/).
- Each person with HIV infection progressing from an earlier or unknown stage to stage 3 (AIDS) diagnosis.
- Each person with HIV infection who has been reported but for whom updated information is available such as new CD4 or viral load tests reported from a medical provider, additional risk factor information, updated current address information, or a change in vital status.

If the data are collected electronically and can be imported, recording the information on a hardcopy form is not necessary.

Definition of Variable Designators

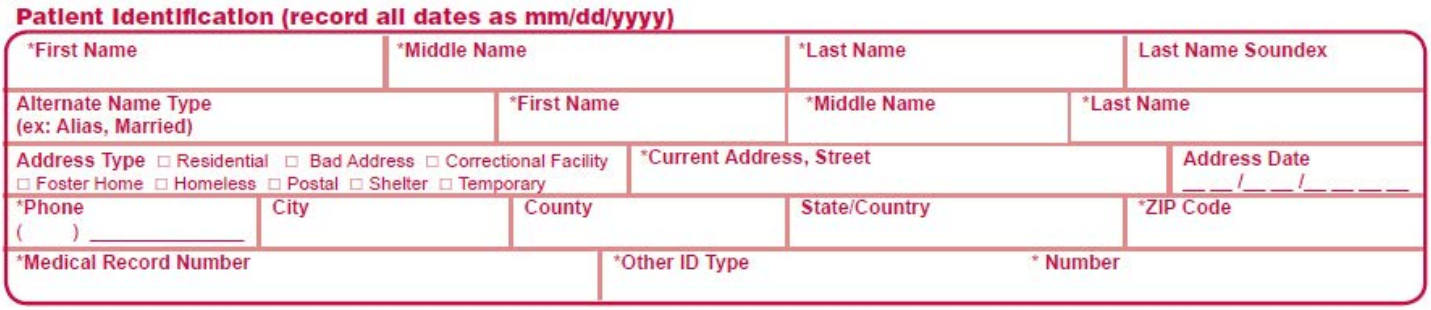
- **Required**: Variables that must be collected by all programs.
- **Recommended**: Variables that programs are strongly encouraged to collect but are not absolutely required.
- **Optional**: Variables that programs may or may not choose to collect.
- **System generated**: Variables where the value is generated by the Centers for Disease Control and Prevention (CDC)-supplied software.

Disposition of Form

- The completed form is for state or local health agency use and is not to be sent to CDC. The Pacific Islands are the only jurisdictions that send forms to CDC for data entry and all patient identifiers must be removed before they are sent.
- Data obtained from these forms are entered into standardized computer software provided by the Division of HIV/AIDS Prevention, National Center for HIV, Viral Hepatitis, STD, and TB

Prevention, CDC, and then transferred without identifiers to CDC by encrypted electronic transfer via a secure data network.

1. Patient Identification



*Information NOT transmitted to CDC

Patient identifier information is for state and local health department use only and is not transmitted to CDC if marked with an * on the form.

1.1 FIRST NAME (**Required**, applies to health department & health care providers)

- Enter patient's first name.

1.2 MIDDLE NAME (**Optional**, applies to health department & health care providers)

- Enter patient's middle name.

1.3 LAST NAME (**Required**, applies to health department & health care providers)

- Enter patient's last name.

1.4 LAST NAME SOUNDEX (**System generated**)

- After patient name is entered into CDC-supplied software, the software automatically generates this variable by using the patient's last name. After the code is generated, health department staff should fill this field on the form.
- This variable is a phonetic, alphanumeric code calculated by converting a surname into an index letter and a three-digit code. The index letter is the first letter of the surname. The *eHARS Technical Reference Guide* describes exactly how the Last Name Soundex is created. You can access the *eHARS Technical Reference Guide* through SharePoint: https://partner.cdc.gov/CookieAuth.dll?GetLogon?curl=Z2FSitesZ2FNCHHSTPZ2FHICSB&reason=0&formdir=6.

1.5 ALTERNATE NAME TYPE (**Optional**, applies to health department & health care providers)

- If available, write in the alternate name type (such as Alias, Married).

1.6 ALTERNATE FIRST NAME (**Optional**, applies to health department & health care providers)

- Enter patient's alternate first name.

1.7 ALTERNATE MIDDLE NAME (**Optional**, applies to health department & health care providers)

- Enter patient's alternate middle name.

1.8 ALTERNATE LAST NAME (**Optional**, applies to health department & health care providers)

- Enter patient's alternate last name.

1.9 ADDRESS TYPE (**Required**, applies to health department & health care providers)
- Select one of the address types for the patient's current address.

1.10 CURRENT ADDRESS, STREET (**Required**, applies to health department & health care providers)
- Enter the patient's current street address.

1.11 ADDRESS DATE (**Required**, applies to health department & health care providers)
- Enter the most recent date through which the patient was known to be residing at the current address specified in 1.10.
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

1.12 PHONE (**Required** if patient has a telephone, applies to health department & health care providers)
- Enter patient's primary area code and telephone number associated with the current address specified in 1.10.

1.13 CITY (**Required**, applies to health department & health care providers)
- Enter patient's current city.

1.14 COUNTY (**Required**, applies to health department & health care providers)
- Enter patient's current county.

1.15 STATE/COUNTRY (**Required**, applies to health department & health care providers)
- Enter patient's current state and country name.

1.16 ZIP CODE (**Required**, applies to health department & health care providers)
- Enter patient's current zip code.

1.17 MEDICAL RECORD NUMBER (**Optional,** applies to health department & health care providers)
- Enter medical record number of the patient if available.
- This field may be left blank unless patient was hospitalized as an inpatient or treated as an outpatient in a hospital, community health center, or health department clinic.
- If the patient has more than one medical record number, enter the number of the primary record that has HIV infection or stage 3 (AIDS) documentation. Additional numbers can be noted in the Comments section annotating which facility is associated with which record number.

1.18–1.19 OTHER ID TYPE and NUMBER (**Optional,** applies to health department & health care providers)
- Enter any additional patient identifier type (such as social security number) and the number of the other identifier. For a list of ID types, please reference the *eHARS Technical Reference Guide*.

2. Health Department Use Only

Health Department Use Only (record all dates as mm/dd/yyyy)

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	

2.1 DATE RECEIVED AT HEALTH DEPARTMENT (**Recommended,** applies to health department)
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

2.2 eHARS DOCUMENT UID (**System generated)**

- Enter UID after CDC-supplied software generates this variable.

2.3 STATE NUMBER (**Required,** applies to health department)

- Enter the assigned state patient number.
- Each patient should have a unique state number throughout the course of HIV disease in each state/jurisdiction where they are reported.
- Assigned numbers **should not** be reused, even if the case is later deleted.
- This variable is used, along with the state of report, to uniquely identify cases reported to CDC and to merge the state datasets without duplication.

2.4 REPORTING HEALTH DEPARTMENT -CITY/COUNTY (**Required,** applies to health department)

- Enter name of city and county of the health department that receives the report from providers of surveillance data.

2.5 CITY/COUNTY NUMBER (**Optional,** applies to health department)

- Enter the assigned city/county patient number.
- Each patient should have a unique city/county number throughout the course of HIV disease assigned by the separately funded city in which they are reported.
- Assigned numbers **should not** be reused, even if the case is later deleted.

2.6 DOCUMENT SOURCE (**Required**, applies to health department)

- Enter the code for the document source that provided the information for this report (formerly report source).
- To clearly identify multiple data sources for a given HIV case (all stages), use a separate case report form for each source.
- Refer to the *eHARS Technical Reference Guide* for a list of the allowable document source codes.

2.7 SURVEILLANCE METHOD (**Required,** applies to health department)

- Enter the method the case report was ascertained.
- For definitions of active, passive, follow up, re-abstraction refer to the file *Source Data and Completeness of Reporting*.

2.8 DID THIS REPORT INITIATE A NEW INVESTIGATION? (**Optional,** applies to health department)

- Enter whether this case report initiated a new investigation by the health department.

2.9 REPORT MEDIUM (**Optional,** applies to health department)

- Health department staff review medical records at provider facilities (i.e., field visits) or receive information over the telephone, by fax, US mail, or other method, to establish an HIV case and to elicit information for HIV case report forms. The health department can also receive HIV case reports from physicians, laboratories, or other individuals or institutions through electronic transfer or CD/disks. Enter the medium in which the case report was submitted.

3. Facility Providing Information

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 ( ) _____

3.1 FACILITY NAME (**Recommended**, applies to health department & health care providers)
- Enter name of the facility providing the information.
- If data was reported from different facilities, enter name of each on separate forms.

3.2 PHONE (**Recommended**, applies to health department & health care providers)
- Enter facility's current area code and telephone number.

3.3 STREET ADDRESS (**Recommended**, applies to health department & health care providers)
- Enter facility's street address.

3.4 CITY (**Recommended**, applies to health department & health care providers)
- Enter city where facility providing information is located.

3.5 COUNTY (**Recommended**, applies to health department & health care providers)
- Enter county where facility providing information is located.

3.6 STATE/COUNTRY (**Recommended**, applies to health department & health care providers)
- Enter state and country name where facility providing information is located.

3.7 ZIP CODE (**Recommended**, applies to health department & health care providers)
- Enter ZIP code where facility providing information is located.

3.8 FACILITY TYPE (**Required**, applies to health department & health care providers)
- Select the type of facility providing information.
- Refer to the *eHARS Technical Reference Guide* for additional information regarding allowable facility types.

3.9 DATE FORM COMPLETED (**Required**, applies to health department & health care providers)
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

3.10 PERSON COMPLETING FORM (**Optional**, applies to health department & health care providers)
- Enter the name of the person completing the form who can be contacted to clarify entries and supply additional information.

3.11 PHONE (**Recommended**, applies to health department & health care providers)
- Enter the telephone number of the person completing the form.

4. Patient Demographics

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/Other Pacific Islander ☐ White ☐ Unknown		**Expanded Race** _____

4.1 SEX ASSIGNED AT BIRTH (**Required**, applies to health department & health care providers)

- Select patient's sex assigned at birth.
- In addition to "Male" or "Female" sex at birth, CDC-supplied software includes a third choice of "Unknown."

4.2 COUNTRY OF BIRTH (**Recommended**, applies to health department & health care providers)

- Select applicable response.
- For patients born in US minor outlying areas, specify the name of the US dependency from the following table:

US Dependencies	
Baker Island	Midway Islands
Howland Island	Navassa Island
Jarvis Island	Palmyra Atoll
Johnston Atoll	Wake Island
Kingman Reef	

- For patients born in any other area outside of the US and US minor outlying areas, specify the country/US dependency name.

4.3 DATE OF BIRTH (**Required**, applies to health department & health care providers)

- Enter patient's date of birth in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

4.4 ALIAS DATE OF BIRTH (**Optional**, applies to health department & health care providers)

- If available, enter the alias date of birth in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

4.5 VITAL STATUS (**Required**, applies to health department & health care providers)

- Enter vital status at time of this report.
- For further guidance on death ascertainment, see the file *Death Ascertainment*.

4.6 DATE OF DEATH (**Required,** if applicable, applies to health department & health care providers)

- If patient is deceased, enter date of death in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- For further guidance on death ascertainment, see the file *Death Ascertainment*.

4.7 STATE OF DEATH (**Required,** if applicable, applies to health department & health care providers)

- If patient is deceased, enter the state name where the death occurred. If the death occurred outside

of the US, enter "Foreign Country".

4.8 CURRENT GENDER IDENTITY (**Recommended,** if applicable, applies to health department & health care providers)

- Complete only if the patient is thought to be transgender.
- Enter the current gender identity of the patient.
- If the person's stated gender identity differs from the selections provided, please check the additional gender identity box and specify in the blank.
- Refer to the lookup codes in the *eHARS Technical Reference Guide* for allowable current gender identity values.

4.9 ETHNICITY (**Required**, applies to health department & health care providers)

- If search for this datum was completed and ethnicity could not be determined or if ethnicity was documented to be unknown, select "Unknown".
- If no search for this datum was completed, leave this field blank.
- Regardless of the availability of data on race, collect data on ethnicity.
- As of January 2003, the US Office of Management and Budget (OMB) required that race and ethnicity (Hispanic/Latino, Not Hispanic/Latino) for a person be collected as separate variables.
- A wide variety of ethnicities may be selected from values available in CDC-supplied software. These ethnicities and codes are documented in the *eHARS Technical Reference Guide.*

4.10 EXPANDED ETHNICITY (**Optional,** if applicable, applies to health department & health care providers)

- Enter more specific ethnicity information for greater detail such as "Hispanic or Latino.Cuban" or "Hispanic or Latino.Puerto Rican".
- Refer to the *eHARS Technical Reference Guide* for listing of expanded ethnicity.

4.11 RACE (**Required**, applies to health department & health care providers)

- Select patient's race even if information was submitted for ethnicity.
- Select more than one race if applicable.
- If no race information is available, select "Unknown".
- As of January 2003, the US Office of Management and Budget (OMB) required that systems collect multiple races for a person (OMB Policy Directive 15 updated standards); at a minimum, collect data on the following five categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.
- Refer to the *eHARS Technical Reference Guide* for further details.

4.12 EXPANDED RACE (**Optional,** if applicable, applies to health department & health care providers)

- Enter more specific race information for greater detail such as "American Indian or Alaska Native.Navajo" or "White.Middle Eastern or North African".
- Refer to the *eHARS Technical Reference Guide* for listing of expanded race.

5. Residence at Diagnosis

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

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			Address Date __ __/__ __/__ __ __ __
City	County	State/Country	*ZIP Code

- Refer to Appendix 5.0 for further guidance.
  - If patient's residence at HIV diagnosis and stage 3 (AIDS) diagnosis are different, enter the address information associated with the stage 3 (AIDS) diagnosis in the Comments section.

5.1 ADDRESS TYPE (**Required**, applies to health department & health care providers)
- Select the address type for the patient's residence at diagnosis.
- If the patient's residence at HIV diagnosis and stage 3 (AIDS) diagnosis was the same, you may check both.

5.2 STREET ADDRESS (**Required**, applies to health department & health care providers)
- Enter street address of residence at diagnosis.

5.3 ADDRESS DATE (**Required**, applies to health department & health care providers)
- Enter the earliest date on or after the date of diagnosis that the patient was known to be residing at the address specified in 5.2.
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

5.4 CITY (**Required**, applies to health department & health care providers)
- Enter city of residence at diagnosis.

5.5 COUNTY (**Required**, applies to health department & health care providers)
- Enter county of residence at diagnosis.

5.6 STATE/COUNTRY (**Required**, applies to health department & health care providers)
- Enter the state and country name of residence at diagnosis.

5.7 ZIP CODE (**Required**, applies to health department & health care providers)
- Enter the ZIP code of residence at diagnosis.

6. State/Local Use Only

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.)

_____ *Phone ( ) _____

Hospital/Facility

_____

The information in this section is not transmitted to CDC and is meant only for state and local health department use. State and local health departments should develop their own policies for collecting the data elements within this section. Collection of information within this section is **Optional**.

7. Facility of Diagnosis

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (Check all that apply to facility below) ☐ HIV ☐ AIDS ☐ 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**	

- If the patient's HIV diagnosis and stage 3 (AIDS) diagnosis occurred at different facilities, enter the stage 3 (AIDS) facility information in the Comments section.

7.1 DIAGNOSIS TYPE (**Recommended**, applies to health department & health care providers)
- Enter the diagnosis type that corresponds to the facility of diagnosis being reported.

7.2 FACILITY NAME (**Recommended**, applies to health department & health care providers)
- Enter name of the facility where patient was first diagnosed which corresponds with the "Diagnosis Type" reported in 7.1.
- Refer to Appendix 7.2 for further details.

7.3 PHONE (**Recommended**, applies to health department & health care providers)
- Enter area code and telephone number of the facility of diagnosis.

7.4 STREET ADDRESS (**Recommended**, applies to health department & health care providers)
- Enter street address of the facility of diagnosis.

7.5 CITY (**Recommended**, applies to health department & health care providers)
- Enter city of the facility of diagnosis.

7.6 COUNTY (**Recommended**, applies to health department & health care providers)
- Enter county of the facility of diagnosis.

7.7 STATE/COUNTRY (**Recommended**, applies to health department & health care providers)
- Enter state and country name of the facility of diagnosis.

7.8 ZIP CODE (**Recommended**, applies to health department & health care providers)
- Enter ZIP code where the facility of diagnosis is located.

7.9 FACILITY TYPE (**Required** applies to health department & health care providers)
- Select the type of facility of diagnosis.
- Refer to the *eHARS Technical Reference Guide* for listing of facility types.

7.10 PROVIDER NAME (**Recommended**, applies to health department & health care providers)
- Enter provider's name where the patient was first diagnosed which corresponds with the "Diagnosis Type" reported in 7.1.

7.11 PROVIDER PHONE (**Recommended**, applies to health department & health care providers)
- Enter area code and telephone number for provider selected in 7.10.

7.12 SPECIALTY (**Optional**, applies to health department & health care providers)
- Enter provider's specialty for provider selected in 7.10.

8. Patient History

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) 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)	☐ Yes ☐ No ☐ Unknown

These data yield information about how patients may have acquired their infections.

- Check box at the top of this section if the risk factor was a pediatric risk factor and enter additional information in the Comments section.
- Respond to each risk factor, selecting "Yes" for all factors that apply; "No" for those that do not apply (only select "No" if medical record specifically states this is not a risk factor); and "Unknown" for those for which investigation failed to yield an answer. If an investigation for a particular item was not performed, then you should leave it blank. Collect data about risk factors that occurred before the earliest known diagnosis of HIV infection. For further guidance, see the file *Risk Factor Ascertainment.*
- See Appendix Section 8.0 for further guidance on risk factor ascertainment.

8.1 SEX WITH MALE (**Required**, applies to health department & health care providers)

- Select applicable response.
- Some examples of information from the medical record which would strongly indicate sex with a male are below.
  - For male patient:
    - Married to or divorced from a male; and
    - Rectal gonorrhea.
  - For female patient:

- Married to or divorced from a male;
- Boyfriend referenced in the medical record;
- Living with a male "partner";
- History of pregnancy;
- History of another sexually transmitted infection (in addition to HIV); and
- Sex worker (either current or in the past).

8.2 SEX WITH FEMALE (**Required**, applies to health department & health care providers)

- Select applicable response.
- Some examples of information from the medical record which would strongly indicate sex with a female are below.
  - For male patient:
    - Married to or divorced from a female; and
    - Has a biological child
  - For female patient:
    - Married to or divorced from a female.

8.3 INJECTED NON-PRESCRIPTION DRUGS (**Required**, applies to health department & health care providers)

- Select applicable response.
- History of injected non-prescription drugs might have occurred at any time in the past

8.4-8.6 RECEIVED CLOTTING FACTOR FOR HEMOPHILIA/COAGULATION DISORDER, SPECIFY CLOTTING FACTOR, and DATE RECEIVED (**Required**, applies to health department & health care providers)

- Select applicable response.
- "Coagulation disorder" or "hemophilia" refers only to a disorder of a clotting factor; factors are any of the circulating proteins named Factor I through Factor XII. These disorders include Hemophilia A and Von Willebrand's disease (Factor VIII disorders) and Hemophilia B (a Factor IX disorder).
- This risk factor is generally documented in the history and physical section of the patient's medical chart.
- They do not include other bleeding disorders, such as thrombocytopenia, treatable by platelet transfusion.
- If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select "No."
- See the file *Risk Factor Ascertainment* for further guidance on risk factor data collection and cases of public health importance (COPHI).
- Alert state/local COPHI coordinator if select "Yes".
- If "Yes", specify the clotting factor and enter date received. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

8.7 HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING: This section, addressed at 8.7.1–8.7.6, relates to ascertainment of risk among persons who had heterosexual contact (had sex with) with the case patient. Verification of sex partner's HIV infection status is not necessary.

8.7.1 INTRAVENOUS/INJECTION DRUG USER (**Required**, applies to health department & health care providers)

- Select applicable response.

8.7.2 BISEXUAL MALE (**Required**, applies to health department & health care providers)
- Select applicable response.
- Applies only to **female** cases.

8.7.3 PERSON WITH HEMOPHILIA/COAGULATION DISORDER WITH DOCUMENTED HIV INFECTION (**Required**, applies to health department & health care providers)
- Select applicable response.
- Refer to 8.4-8.6 for additional information.

8.7.4 TRANSFUSION RECIPIENT WITH DOCUMENTED HIV INFECTION (**Required**, applies to health department & health care providers)
- Select applicable response.
- Consider documenting the reason for transfusion in the Comments section.

8.7.5 TRANSPLANT RECIPIENT WITH DOCUMENTED HIV INFECTION (**Required**, applies to health department & health care providers)
- Select applicable response.
- Consider documenting the reason for transplant in the Comments section.

8.7.6 PERSON WITH DOCUMENTED HIV INFECTION, RISK NOT SPECIFIED (**Required**, applies to health department & health care providers)
- Select applicable response.
- Select "Yes" only if HETEROSEXUAL sex partner is known to be HIV positive and that partner's risk factor for HIV is unknown.

8.8-8.10 RECEIVED TRANSFUSION OF BLOOD/BLOOD COMPONENTS (OTHER THAN CLOTTING FACTOR), FIRST DATE RECEIVED, and LAST DATE RECEIVED (**Required**, applies to health department & health care providers)
- Select applicable response.
- Blood is defined as a circulating tissue composed of a fluid portion (plasma) with suspended formed elements (red blood cells, white blood cells, platelets).
- Blood components that can be transfused include erythrocytes, leukocytes, platelets, and plasma.
- It is often helpful to document the reason for the transfusion in the Comments section.
- See the file *Risk Factor Ascertainment* for further guidance on risk factor data collection and COPHI.
- If the last transfusion was after March 1985, then alert state/local COPHI coordinator.
- If "Yes", enter the dates first and last received in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

8.11 RECEIVED TRANSPLANT OF TISSUE/ORGANS OR ARTIFICIAL INSEMINATION (**Required**, applies to health department & health care providers)
- Select applicable response.
- See the file *Risk Factor Ascertainment* for further guidance on risk factor data collection and COPHI.
- Alert the state/local COPHI coordinator if select "Yes".

8.12-8.13WORKED IN HEALTH CARE OR CLINICAL LABORATORY SETTING and IF OCCUPATIONAL EXPOSURE IS BEING INVESTIGATED OR CONSIDERED AS PRIMARY MODE OF EXPOSURE, SPECIFY OCCUPATION AND SETTING (**Required** applies to health department & health care providers)

- Select applicable response.
- Investigate apparent occupational exposures to determine if this was the only risk factor present.
- See the file *Risk Factor Ascertainment* for further guidance on risk factor data collection and COPHI.
- Alert state/local COPHI coordinator if select "Yes".
- If "Yes", specify occupation and setting.

8.14 OTHER DOCUMENTED RISK (**Required** applies to health department & health care providers)

- See the file *Risk Factor Ascertainment* for further guidance on unusual transmission history that could be considered as potential COPHI.
- Select applicable response.
- Document details of the risk information in the Comments section.

9. Laboratory Data

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Non-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

TEST 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT*: HIV-1 Ag
☐ Reactive ☐ Nonreactive ☐ Not Reported
Collection Date: __ __ /__ __ /__ __ __ __

HIV-Ab
☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV Ab

HIV Detection Tests (Qualitative)

TEST: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ 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 at or after diagnosis

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

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

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

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis: __ __ /__ __ /__ __ __ __

Date of last documented negative HIV test (before HIV diagnosis date): __ __ /__ __ /__ __ __ __ Specify type of test: _____

Throughout this section, "Collection Date" refers to the date when the specimen was collected or drawn. Enter collection dates in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

Record all laboratory tests. Include all diagnostic, viral load, and CD4 tests where possible. Where number of tests exceeds the number of fields available on the form, record such results in the Comments section. In the absence of lab tests, record HIV infection or stage 3(AIDS) diagnostic evidence documented in the chart by a physician.

9.1 HIV IMMUNOASSAYS (NON-DIFFERENTIATING)

- Assuming active case finding, review patient's chart and lab reports for the earliest date of

documented HIV positivity. "Indeterminate" refers to Indeterminate HIV antibody test results.

- Enter results and collection dates for all tests that are part of the first diagnostic testing algorithm whose overall interpretation is positive (that the patient is HIV-infected).
- Enter specimen collection date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- Check the Rapid Test box if the test is rapid.
- Enter the brand name of the test and/or its manufacturer.

9.1.1 HIV-1 IA (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of first HIV-1 IA.
- "Positive IA" means repeatedly reactive tests on a single sample.

9.1.2 HIV-1/2 IA (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of first HIV-1/2 combination IA test.

9.1.3 HIV-1/2 AG/AB (each element **Required**, applies to health department & health care providers)

- Enter results and collection date of combined p24 antigen and anti HIV1/2 antibody screening assay.

9.1.4 HIV-1 WESTERN BLOT (each element **Required**, applies to health department & health care providers)

- Enter the result and collection date of first HIV-1 Western blot.
- Western blot banding patterns should be interpreted according to the CDC/Association of State and Territorial Public Health Laboratory Directors (ASTPHLD) recommendations "Human Immunodeficiency Virus Type 1 Infections" (*MMWR*, 1989:38:No.S-7).

9.1.5 HIV-1 IFA (each element **Required**, applies to health department & health care providers)

- Enter the result and collection date of first HIV-1 IFA.

9.1.6 HIV-2 IA (each element **Required**, applies to health department & health care providers)

- Enter result and date of first HIV-2 IA.
- "Positive IA" means repeatedly reactive tests on a single sample.

9.1.7 HIV-2 WESTERN BLOT (each element **Required,** applies to health department & health care providers)

- Enter the result and collection date of first HIV-2 Western blot.

9.2 HIV IMMUNOASSAYS (DIFFERENTIATING) (each element **Required,** applies to health department & health care providers)

- Assuming active case finding, review patient's chart and lab reports for the earliest date of documented HIV positivity.
- Enter results and collection dates for all tests that are part of the first diagnostic testing algorithm whose overall interpretation is positive (that the patient is HIV-infected).
- Enter specimen collection date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- Check the Rapid Test box if the test is rapid.
- Enter the brand name of the test and/or its manufacturer.

9.2.1 HIV-1/2 TYPE-DIFFERENTIATING (each element **Required**, applies to health department &

health care providers)

- Enter result and collection date of first HIV-1/2 Type Differentiating IA.
- If reports indicate HIV-1 and HIV-2 results separately, verify with the laboratory that a type-differentiating test was performed, and enter appropriate results for a type-differentiating test (i.e., not separate HIV-1 and HIV-2 IAs).
- If the result is HIV-1 reactive and HIV-2 reactive, check the box for "Both (undifferentiated)" on the ACRF. This indicates that antibodies to both HIV-1 and HIV-2 were detected.

9.2.2 HIV-1/2 AG/AB-DIFFERENTIATING (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of first HIV-1/2 Ag/Ab-Differentiating IA.
- If the result is HIV Ab reactive or HIV-1 Ag reactive and HIV Ab reactive, check the box for "Ab reactive" or "Both (Ag and Ab reactive)", respectively, on the ACRF. These indicate that antibodies to HIV-1 or HIV-2 were detected.

9.2.3 HIV-1/2 AG/AB and TYPE-DIFFERENTIATING (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of first HIV-1/2 Ag/Ab and Type-Differentiating IA.
- Record the result for both HIV-1 Ag and HIV Ab. (That is, one result should be recorded for HIV-1 Ag, and one result should be recorded for HIV Ab.)

9.3 HIV DETECTION TESTS (QUALITATIVE) (each element **Required**, applies to health department & health care providers)

- All varieties of such tests establish the presence of the pathogen, HIV. By contrast, HIV tests such as the IA or Western blot establish the presence of the immune system's response to the pathogen (i.e., HIV antibodies).
- Assuming active case finding, review patient's chart and lab reports for the earliest date of documented HIV positivity.
- Enter results and collection dates for all tests that are part of the first diagnostic testing algorithm whose overall interpretation is positive (that the patient is HIV-infected).
- Enter specimen collection date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

9.3.1 HIV-1 RNA/DNA NAAT (QUAL) (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of earliest NAAT.

9.3.2 HIV-1 CULTURE (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of earliest test by culture.

9.3.3 HIV-2 RNA/DNA NAAT (QUAL) (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of earliest NAAT.

9.3.4 HIV-2 CULTURE (each element **Required**, applies to health department & health care providers)

- Enter result and collection date of earliest test by culture.

9.4 HIV DETECTION TESTS (QUANTITATIVE VIRAL LOAD) (each element **Required**, applies to health department & health care providers)

- Indicate if results are "Detectable" or "Undetectable". Viral load tests with undetectable results should also be entered.
- Enter results in units of viral copies per milliliter (mL) and Log. Where detectable results are reported with log data only, enter "greater than detection limits for this assay" under the copies/mL field. Because undetectable results are typically reported as below the detection limits of the assay rather than by a specific quantitative value, enter "fewer than detectable by this assay" under the copies/mL field.
- Enter specimen collection date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

9.4.1 HIV-1 RNA/DNA NAAT (QUANTITATIVE VIRAL LOAD) (each element **Required**, applies to health department & health care providers).

- Enter result and collection date of earliest test.

9.4.2 HIV-2 RNA/DNA NAAT (QUANTITATIVE VIRAL LOAD) (each element **Required**, applies to health department & health care providers).

- Enter result and collection date of earliest test.

9.5 IMMUNOLOGIC TESTS (CD4 COUNT AND PERCENTAGE) (each element **Required**, applies to health department & health care providers)

- Whenever CD4 count and percentage are both available for the same specimen collection date, record both.
- Enter specimen collection date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

9.5.1 CD4 AT OR CLOSEST TO DIAGNOSIS

This is the first CD4 result closest to the date of initial HIV infection diagnosis, regardless of stage of disease at diagnosis.

9.5.1.1 CD4 COUNT (each element **Required**, applies to health department & health care providers)

- Record the CD4 count closest to the time when the patient was determined to be HIV infected. If this information is not available when the initial case report is completed, it may be entered later.
- Enter result and specimen collection date of first CD4 count.

9.5.1.2 CD4 PERCENTAGE (each element **Required**, applies to health department & health care providers)

- Record the CD4 percentage closest to the time when the patient was determined to be HIV infected. If this information is not available when the initial case report is completed, it may be entered later.
- Record result and specimen collection date of first CD4 percentage.

9.5.2 FIRST CD4 RESULT < 200 cells/μL or < 14%

This is the first CD4 result indicative of stage 3 (AIDS). The stage is based primarily on the CD4 count; the CD4 count takes precedence over the CD4 percentage, and the percentage is considered only if the count is missing.

9.5.2.1 CD4 COUNT (**Required**, applies to health department & health care providers)

- Record results and specimen collection date of first CD4 indicative of stage 3 (i.e., < 200 cells/μL).

9.5.2.2 CD4 PERCENTAGE (**Required**, applies to health department & health care providers)

- Record results and specimen collection date if:
  - The CD4 percentage was from a specimen collected on the same date as the first CD4 count indicative of stage 3 (see section 9.5.2.1 above) or
  - The first CD4 percentage indicative of stage 3 (i.e., <14%) was from a specimen collected on an earlier date than the first CD4 count indicative of stage 3 and was not accompanied by a CD4 count for the same date.

9.5.3 Other CD4 RESULT

9.5.3.1 CD4 COUNT (**Required**, applies to health department & health care providers)

- Enter results and specimen collection date of other CD4 count.

9.5.3.2 CD4 PERCENTAGE (**Required**, applies to health department & health care providers)

- Record results and specimen collection date of other CD4 percentage.

9.6 DOCUMENTATION OF TESTS

9.6.1 DID DOCUMENTED LABORATORY TEST RESULTS MEET APPROVED HIV DIAGNOSTIC ALGORITHM CRITERIA? (**Required** if applicable, applies to health department & health care providers)

- This section captures diagnoses through novel algorithms, and should only be completed if none of the following were positive: HIV-1 Western blot; IFA, culture, viral load; or qualitative NAAT (RNA or DNA).
- "Approved HIV diagnostic algorithm criteria" means any criteria that satisfy the HIV surveillance case definition, regardless of whether approved for other purposes such as laboratory-based HIV testing or point-of-care HIV screening.
- If "Yes", enter date of earliest positive test for this algorithm in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

9.6.2 IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY A PHYSICIAN? (**Required** if applicable, applies to health department & health care providers)

- If laboratory evidence of an HIV test is unavailable in the patient's medical or other record and written documentation of lab evidence of HIV infection consistent with the HIV case definition is noted by the physician, enter "Yes"; otherwise enter "No" or "Unknown."
- IF "YES" TO 9.6.2, PROVIDE DATE OF DIAGNOSIS BY PHYSICIAN (**Required** in the absence of lab results, applies to health department & health care providers)
- Date of diagnosis is defined as the date (at least the year) of diagnosis reported in the content of the medical record. If the diagnosis date was not reported in the note, the date when the note was written can be used as a proxy. For example, if a health care provider writes a note in a medical chart on 4/10/2010 stating the patient had positive HIV EIA and WB on 2/11/2010, this should be recorded as 2/11/2010 as the date of diagnosis by the physician.

9.6.3 DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (SPECIFY TYPE) (**Recommended** for all surveillance areas and **Required** for HIV incidence surveillance,

applies to health department & health care providers)

- This represents the last documented date when the person was considered not to be HIV infected, as documented by laboratory or medical record evidence accompanied by test type information.
- Patient self-report of last negative test is not considered "documented" and thus should not be entered in this field but rather in the HIV Testing History section (see sections 13.5 and 13.6 below).
- Enter the specimen collection date for the date of the last negative HIV test in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- Enter the type of test that yielded the last negative HIV test result.
- Include the last negative HIV laboratory test result before the person was known to be infected. Do not include a negative test result as part of a sequence of tests in an algorithm that has a final interpretation indicating that the person was infected with HIV.
- If it is unclear how to interpret a negative test result that is part of a testing algorithm, it may be necessary to contact the provider ordering the tests.
- Do not include an undetectable viral load result, as this result alone is not considered sufficient evidence of the absence of HIV infection (e.g., the person may have been receiving antiretroviral therapy when the specimen was obtained, or may naturally have a suppressed viral load without antiretroviral therapy).
- Do not include tests with indeterminate, inconclusive, or unknown results.

10. Clinical

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

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx 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:

10.1 CLINICAL

10.1.1–10.1.26 (**Optional,** applies to health department & health care providers)

- Select all that apply and enter diagnosis dates. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- For additional information, refer to the most recent case definition for HIV infection (available at http://wwwn.cdc.gov/nndss/conditions/hiv-infection/).

10.1.27 RVCT CASE NUMBER (**Optional,** applies to health department & health care providers)

- If this patient has a verified case of tuberculosis (TB), health department staff enter the

nine-digit alphanumeric code from the TB case report or TB data management system. Providers in the private and public sectors diagnosing tuberculosis in their stage 3 (AIDS) patients may get this number from TB surveillance staff.

11. Treatment/Services Referrals

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 Comments)			
*Child's Name	Child's Last Name Soundex	Child's Date of Birth __ __/__ __/__ __ __ __	
*Child's Coded ID	Child's State Number		
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone ( ) _____	
Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Other, specify _____	*Other Facility*: ☐ Emergency Room ☐ Corrections ☐ Unknown ☐ Other, specify _____	*ZIP Code
*Street Address	City	County	State/Country

11.1 HAS THIS PATIENT BEEN INFORMED OF HIS/HER HIV INFECTION (**Optional**, applies to health department & health care providers)

- Select applicable response
- If notification is not documented, select "Unknown" unless the person completing the form knows with certainty that the patient is aware of the infection.

11.2 THIS PATIENT'S PARTNERS WILL BE NOTIFIED ABOUT THEIR HIV EXPOSURE AND COUNSELED BY (**Optional**, applies to health department & health care providers)

- Select applicable response.

11.3 FOR FEMALE PATIENT

11.3.1 THIS PATIENT IS RECEIVING OR HAS BEEN REFERRED FOR GYNECOLOGICAL OR OBSTETRICAL SERVICES (**Optional**, applies to health department & health care providers)

- Select applicable response.

11.3.2 IS THIS PATIENT CURRENTLY PREGNANT (**Required,** applies to health department & health care providers)

- Response is dependent on which date was selected for populating the field 3.9 (DATE FORM COMPLETED). If patient was pregnant on that date, select "Yes".

11.3.3 HAS THIS PATIENT DELIVERED LIVE-BORN INFANTS (**Optional**, applies to health department & health care providers)

- Select applicable response.
- If "Yes", provide birth information for the most recent birth as described at 11.4 below.

11.4 FOR CHILDREN OF PATIENT

- Record information related to the most recent birth in this section. Record additional or multiple births in the Comments section.

11.4.1 CHILD'S NAME (**Recommended,** applies to health department & health care providers)

- Enter child's first name, middle name, and last name.

11.4.2 CHILD'S LAST NAME SOUNDEX (**System generated**)

- After the child's name is entered into CDC-supplied software, the software automatically generates this variable by using the child's last name. After the code is generated, health department staff should fill this field on the form.
- This variable is a phonetic, alphanumeric code calculated by converting a surname into an index letter and a three-digit code. The index letter is the first letter of the surname. The *eHARS Technical Reference Guide* describes exactly how the Last Name Soundex is created.

11.4.3 CHILD'S DATE OF BIRTH (**Recommended,** applies to health department & health care providers)

- Enter child's date of birth in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

11.4.4 CHILD'S CODED ID (**Optional**, applies to health department)

- Enter child's non-named coded identifier, if applicable.

11.4.5 CHILD'S STATE NUMBER (**Recommended,** applies to health department)

- Enter the assigned state patient number, if applicable. This number is typically assigned by state/local health department personnel if the child is known to have received a diagnosis of HIV (all stages). Some jurisdictions also assign numbers for children classified as "Perinatally HIV Exposed" or "Seroreverter."
- Assigned numbers **should not** be reused, even if the case is later deleted.
- This variable is used, along with the state of report, to uniquely identify cases reported to CDC and to merge the state datasets without duplication.

11.4.6 FACILITY NAME OF BIRTH (**Optional**, applies to health department & health care providers)

- Enter the name of the facility where the child was born.
- If the child was born at home, enter "home birth".

11.4.7 PHONE (**Optional**, applies to health department & health care providers)

- Enter area code and telephone number of the facility of birth.

11.4.8 FACILITY TYPE (**Optional**, applies to health department & health care providers)

- Select the type of facility of birth.
- Refer to the *eHARS Technical Reference Guide* for listing of facility types.

11.4.9 ZIP CODE (**Optional**, applies to health department & health care providers)

- Enter ZIP code where the facility of birth is located.

11.4.10 STREET ADDRESS (**Optional**, applies to health department & health care providers)

- Enter street address of the facility of birth.

11.4.11 CITY (**Optional**, applies to health department & health care providers)

- Enter city of the facility of birth.

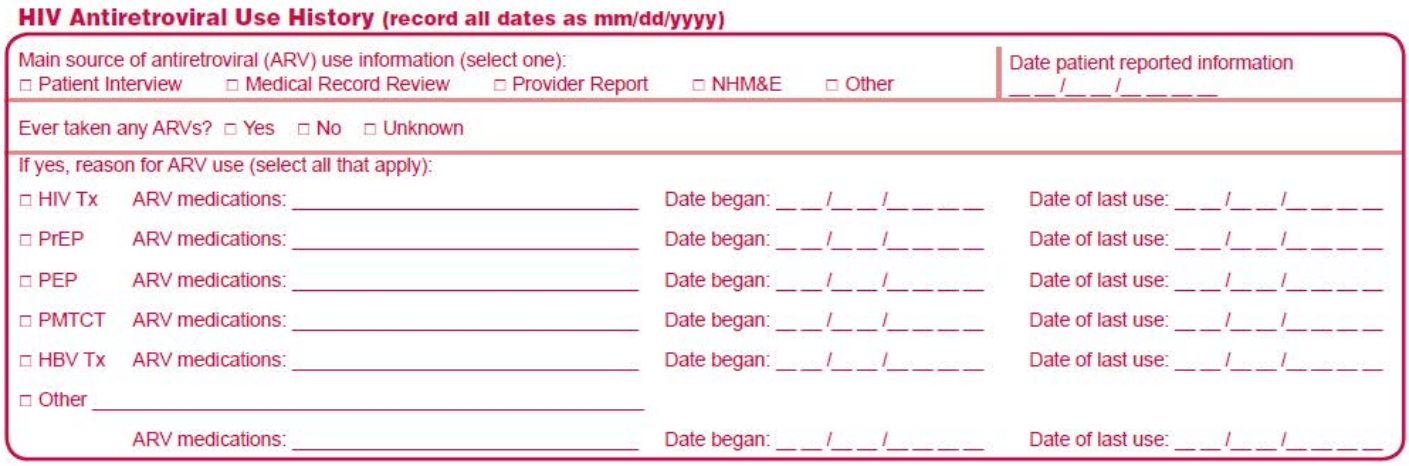
11.4.12 COUNTY (**Optional**, applies to health department & health care providers)

- Enter county of the facility of birth.

11.4.13 STATE/COUNTRY (**Optional**, applies to health department & health care providers)

- Enter state and country name of the facility of birth.

12. HIV Antiretroviral Use History



HIV Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one):
□ Patient Interview □ Medical Record Review □ Provider Report □ NHM&E □ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever taken any ARVs? □ Yes □ No □ Unknown

If yes, reason for ARV use (select all that apply):

□ HIV Tx	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
□ PrEP	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
□ PEP	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
□ PMTCT	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
□ HBV Tx	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
□ Other _____			
	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __

Collection of HIV antiretroviral (ARV) use history information is **required** for state and local health departments that conduct **HIV Incidence Surveillance (HIS) or Molecular HIV Surveillance (MHS)**. This section is **recommended** for **all other surveillance areas**. For HIS, information on ARV use history and testing (refer to Section 13) are used along with the serologic testing algorithm for recent HIV seroconversion (STARHS) results to generate national, state and local HIV incidence estimates. For MHS, ARV use history data are used to assess the prevalence of acquired and transmitted HIV drug resistance.

Unlike other sections on the ACRF, patient self-reported information is accepted for all answers. For additional information, consult the file *HIV Incidence Surveillance* or the file *Molecular HIV Surveillance*.

12.1 MAIN SOURCE OF ANTIRETROVIRAL (ARV) USE INFORMATION (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas**,** applies to health department & health care providers)

- Check only one source (the main source from which the information in this section was obtained).
  - "*Patient Interview*" should be selected only if the patient was directly asked a series of questions from this or another structured form. Interviewer should have been trained on the proper collection of ARV use history data.
  - "*Medical Record Review*" indicates that this information was obtained through abstraction of medical charts, electronic medical records or databases.
  - "*Provider Report*" indicates this form was filled out by a health care provider.
  - "*NHM&E"* indicates that data were abstracted from the National HIV Monitoring and Evaluation (NHM&E) project forms or databases.
  - "*Other"* indicates that information came from a source other than those listed above.

12.2 DATE PATIENT REPORTED INFORMATION (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas**,** applies to health department & health care providers)

- The appropriate date to enter depends on the MAIN SOURCE OF ARV USE INFORMATION. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- If there was a structured patient interview, enter the date of the interview.
- For a medical record review, enter the date of the last patient encounter that contributed to the ARV information collected. If there was no patient encounter, then enter the date the medical record review was performed.
- If the ACRF was completed by a health care provider, enter the date of the last patient encounter when the most recent ARV information was obtained from the patient. If the provider information was obtained from another data source, enter the date of receipt of the information. If no such dates are available, enter the date the ACRF was completed.
- For information obtained through NHM&E, use the date entered on the HIV Test Form.
- If there are no data available from the above sources, enter the date the ACRF was completed.

12.3 EVER TAKEN ANY ARVS (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- This variable indicates whether the patient has ever taken any antiretroviral medication. This is important for HIS because ARV use may affect STARHS results. This variable is also used for MHS to assess HIV drug resistance.
- "Yes" indicates there is evidence that the person has taken ARVs, including self-report. If "Yes", it is important to enter the dates when use began and, if appropriate, ended. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- "No" indicates there is evidence that the patient has never taken ARVs.
- "Unknown" should be used when the person completing the form does not know whether or not the patient has ever taken ARVs, after searching for the information or asking the patient. Leave the field blank if there was no attempt to find the information.

12.4 IF YES, REASON FOR ARV USE (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- Select all that apply.
- "HIV Tx" indicates that the patient used ARVs to treat HIV infection.
- "PrEP" indicates that the patient used ARVs prior to HIV diagnosis for HIV pre-exposure prophylaxis (PrEP).
- "PEP" indicates that the patient used ARVs as post-exposure prophylaxis (PEP).
- "PMTCT" indicates that the patient used ARVs to prevent HIV mother-to-child-transmission during pregnancy.
- "HBV Tx" indicates that the patient used ARVs to treat hepatitis B virus infection.
- "Other" indicates that the patients used ARVs for a reason other than those indicated above.

12.5 ARV MEDICATIONS (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- For each ARV use reason indicated in 12.4, list the medications taken.
- This variable is used to verify that the medication taken was actually an antiretroviral.
- It is not necessary to list every drug combination that may have been used; record at least one

ARV. Enter "unspecified" if an ARV was taken but the name is not known.

12.6 DATE BEGAN (**Required f**or areas conducting HIS/MHS, **recommended** for all other surveillance areas**,** applies to health department & health care providers)

- For each ARV use reason indicated in 12.4, enter the earliest date that the patient took the ARVs, even if ARV use was sporadic.
- If the first time ARVs were taken occurred after HIV diagnosis, it is very important to enter a date, even an estimated date, later than the date of HIV diagnosis.
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

12.7 DATE OF LAST USE (**Required** for areas conducting HIS/MHS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- For each ARV use reason indicated in 12.4, enter the last known date of ARV use.
- For patients currently on ARVs, record the date of the last prescription or known usage. If the information was collected during a patient interview, the date would be the interview date. If the information was collected as part of a medical record review, record the date of the last prescription or date of the last physician's note.
- Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

13. HIV Testing History

HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one): □ Patient Interview □ Medical Record Review □ Provider Report □ NHM&E □ Other	Date patient reported information __ __/__ __/__ __ __ __
Ever had previous positive HIV test? □ Yes □ No □ Unknown	Date of first positive HIV test __ __/__ __/__ __ __ __
Ever had a negative HIV test? □ Yes □ No □ 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 # _____ □ Unknown	

Collection of HIV testing history is **required** for state and local health departments that conduct **HIV Incidence Surveillance (HIS)**. This section is **recommended** for **all other surveillance areas**. For HIS, information on testing and antiretroviral use history (refer to Section 12) are used along with the serologic testing algorithm for recent HIV seroconversion (STARHS) results to generate national, state, and local HIV incidence estimates.

Unlike other sections on the ACRF, patient self-reported information is accepted for all answers. For detailed instructions, consult the file *HIV Incidence Surveillance*.

13.1 MAIN SOURCE OF TESTING HISTORY INFORMATION (**Required** for areas conducting HIS, **recommended** for all other surveillance areas**,** applies to health department & health care providers)

- Check only one source (the main source from which the information in this section was obtained).
  - "*Patient Interview*" should be selected only if the patient was directly asked a series of questions from this or another structured form. Interviewer should have been trained on the proper collection of testing history data.

- "*Medical Record Review"'* indicates that this information was obtained through abstraction of medical charts, electronic medical records, or databases. Information may also have come from a database of HIV test results or pharmacy records.
- "*Provider Report*" indicates this form was filled out by a health care provider.
- "*NHM&E"* indicates that data were abstracted from the National HIV Monitoring and Evaluation (NHM&E) project forms or databases.
- "*Other*" indicates that information came from a source other than those listed above.

13.2 DATE PATIENT REPORTED INFORMATION (**Required** for areas conducting HIS, **recommended** for all other surveillance areas**,** applies to health department & health care providers)

- The appropriate date to enter depends on the MAIN SOURCE OF TESTING HISTORY INFORMATION. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- For a medical record review, enter the date of the last patient encounter that contributed to the testing history information collected. If only a lab report was accessed, enter the date of receipt of the lab results. If there was no patient encounter or lab test receipt date, then enter the date the medical record review was performed.
- If there was a structured patient interview, enter the date of the interview.
- If the ACRF was completed by a health care provider, enter the date of the last patient encounter when the most recent testing history information was obtained from the patient. If provider's information only came from another data source, such as a lab report, enter the date of receipt of the information. If there are no such dates, enter the date the ACRF was completed.
- For information obtained through NHM&E, use the date entered on the HIV Test Form.
- If there are no data available from the above sources, enter the date the ACRF was completed.

13.3 EVER HAD PREVIOUS POSITIVE HIV TEST (**Required** for areas conducting HIS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- The purpose of this variable is to ascertain whether a positive HIV test occurred earlier than the current HIV diagnosis date, but was not reported to the HIV surveillance system. For example, a patient could have been diagnosed in another state/country or tested anonymously.
- Self-reported information is acceptable.
- "Yes" indicates sufficient evidence that there was a previous positive HIV test.
- "No" indicates sufficient evidence that there was no previous positive HIV test.
- "Unknown" indicates that there is lack of evidence about previous HIV tests. Select "Unknown" if the patient refused to answer the question, if the facility refused to permit medical record review, or if the patient, chart reviewer, or provider had no knowledge of whether or not there was a previous positive HIV test after searching for the information or asking the patient.
- The field should be left blank if the medical record was not searched or the question was not asked.
- Do not include indeterminate HIV tests, false positive tests, and tests with inconclusive or unknown results.

13.4 DATE OF FIRST POSITIVE HIV TEST (**Required** for areas conducting HIS, **recommended** for

all other surveillance areas**,** applies to health department & health care providers)

- "Yes" indicates that there was a known previous positive HIV test. Record the date of the earliest known positive HIV test, including patient self-reported dates and anonymous tests. It is acceptable to enter an estimated or incomplete date, as long as it contains a year. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).
- "No" indicates there were no known previous positive HIV tests. Enter the date of the current positive HIV test (i.e., the collection date of the current diagnostic HIV test).
- If you do not know the date of HIV diagnosis, enter the earliest known positive HIV test.
- Do not include indeterminate HIV tests, false positive tests, and tests with inconclusive or unknown results.

13.5 EVER HAD A NEGATIVE HIV TEST (**Required** for areas conducting HIS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- This variable ascertains whether or not the person ever had a negative HIV test result at any time in the past that indicated the person was not HIV infected. Because this variable is used to classify persons as new or previous testers for incidence estimation, it is important to not make assumptions. The mere absence of information about previous tests in a medical record should not be recorded as "No", since tests can occur in other venues. Do not include a negative test result as part of a sequence of tests in an algorithm that has a final interpretation indicating that the person was infected with HIV.
- Self-reported information is acceptable for this data field.
- "Yes" indicates there is knowledge of a previous negative HIV test, either self-reported or confirmed by a laboratory report.
- "No" indicates there is evidence that the person never had a negative HIV test (e.g., person states they have never been tested before). Do not enter "No" if there is simply no evidence either way about a previous HIV test.
- "Unknown" indicates there is insufficient evidence supporting or denying the occurrence of a negative HIV test, after searching for the information or asking the patient. Leave the field blank if there was no attempt to find the information.
- Do not include an undetectable viral load result, as this result alone is not considered sufficient evidence of the absence of HIV infection (e.g., the person may have been receiving antiretroviral therapy when the specimen was obtained, or may naturally have a suppressed viral load without antiretroviral therapy).
- Do not include tests with indeterminate, inconclusive, or unknown results.

13.6 DATE OF LAST NEGATIVE HIV TEST (**Required** for areas conducting HIS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- This variable represents the last date when the person was considered not to be HIV infected, based on self-reported information, or by physician or testing site reports that do not have documented laboratory test result and type information. For incidence estimation, this date is used to categorize persons as repeat testers and to estimate frequency of testing.
- Negative HIV test dates documented by a laboratory report or medical record accompanied by test type information should be entered in the Laboratory Data section (9.6.3) and not here. Incomplete dates are acceptable if the year is included. Enter date in *mm/dd/yyyy* format using '..' for unknown values (e.g., 03/../2011).

- Do not include a negative test result as part of a sequence of tests in an algorithm that has a final interpretation indicating that the person was infected with HIV.
- Do not include an undetectable viral load result, as this result alone is not considered sufficient evidence of the absence of HIV infection (e.g., the person may have been receiving antiretroviral therapy when the specimen was obtained, or may naturally have a suppressed viral load without antiretroviral therapy).
- Do not include tests with indeterminate, inconclusive, or unknown results.

13.7 NUMBER OF NEGATIVE HIV TESTS WITHIN 24 MONTHS BEFORE FIRST POSITIVE TEST (**Required** for areas conducting HIS, **recommended** for all other surveillance areas, applies to health department & health care providers)

- Count the number of negative HIV tests in the 24 months before the first positive HIV test.
- Enter "0" if it is known that the patient has never been tested for HIV before or never had a negative test. Do not enter "0" if there is simply no evidence about a previous HIV test.
- "Unknown" indicates the patient refused to answer the question, the facility refused to permit medical record review, the patient does not remember whether they had a negative test, or the provider or abstractor has no evidence about whether or not there was a previous test. Leave the field blank if there was no attempt to find the information.
- Do not include a negative test result as part of a sequence of tests in an algorithm that has a final interpretation indicating that the person was infected with HIV.
- Do not include an undetectable viral load result, as this result alone is not considered sufficient evidence of the absence of HIV infection (e.g., the person may have been receiving antiretroviral therapy when the specimen was obtained, or may naturally have a suppressed viral load without antiretroviral therapy).
- Do not include tests with indeterminate, inconclusive, or unknown results.

14. Comments (**Optional**, applies to health department & health care providers)

- This section can be used for information not requested on the form or for information requested but where there might not be room in the space provided.
- Information entered into the "Comments" tab on the ACRF of the CDC-supplied software will not be transmitted to CDC.

***Local/Optional Fields**

- This section is for collection of data that are not on the form at the state and local level.
- This information is not sent to CDC.

Appendix: Adult HIV Confidential Case Report (CDC 50.42A)

Instructions for Completion

5.0 Residence at Diagnosis

- Residence may be identical to that listed above in Patient Identification, unless otherwise noted in the chart.
- For HIV, stage 0, 1, 2, and unknown case reports, enter residence at the time of the first positive confirmatory test for HIV infection.
- If a diagnostic test result is not available, enter patient's residence at the date of *physician diagnosis* of HIV infection.
- For HIV, stage 3 (AIDS) case reports, enter patient's residence at the date of the first stage 3 (AIDS) diagnosis based on the applicable case definition.

Residence assignment can be problematic for patients who:

- Have multiple residences
- Are on vacation
- Reside at a school
- Are foster children
- Are members of the armed forces
- Are institutionalized in correctional or other types of facilities
- Are foreign to the United States
- Are US citizens diagnosed abroad

For further guidance about residency assignment, see the file *Date and Place of Residence* .

7.0 Facility of Diagnosis

7.2 FACILITY NAME

- For HIV, stage 0, 1, 2, and unknown case reports, enter the name of the facility where the patient first had blood drawn and was given a diagnosis of HIV infection.
- If test results are not in the medical record, enter the name of the facility where the patient's HIV infection was diagnosed and documented by the health care provider.
- For HIV, stage 3 (AIDS) case reports, enter the name of the facility where the patient was first diagnosed with stage 3 (AIDS) based on the applicable case definition.
- Enter facility uniformly to prevent the occurrence of multiple names for a given facility.

8.0 Patient History

- This information is often found in a discharge summary, history and physical, social service notes, counseling and testing notes, and STD diagnosis notes.
- Where not explicitly annotated, contact patient's provider about risk factor information.
- See the file *Risk Factor Ascertainment* for further guidance on risk factor data collection.
- This information can be difficult to find, particularly if the patient has not been interviewed.

States should have risk factor ascertainment procedures tailored to their jurisdictions.