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

National HIV Surveillance System (NHSS)

Attachment 3a.

Adult HIV Confidential Case Report Form

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

*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 Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( ) _____	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type	* Number	

U.S. Department of Health & Human Services

Adult HIV Confidential Case Report Form

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

Centers for Disease Control and Prevention

Form approved OMB no. 0920-0573 Exp. XX/XX/XXXX

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	

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/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race _____

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

STATE/LOCAL USE ONLY

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

_____ *Phone ( ) _____

Hospital/Facility

_____

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**

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

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. Information in CDC's National HIV 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).

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: _____

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:

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

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: __ __/__ __/__ __ __ __

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

Comments

*Local/Optional Fields