

**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 <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				*Current Address, Street			Address Date ____/____/____
*Phone (____) _____		City		County		State/Country	
*Medical Record Number				*Other ID Type		*Number	

U.S. Department of Health  
and Human Services**Adult HIV Confidential Case Report Form**  
(Patients ≥13 years of age at time of diagnosis) \*Information NOT transmitted to CDCCenters for Disease Control  
and Prevention (CDC)**Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. NNNN-NNNN Exp. 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 <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown			
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 6-CD/disk			

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

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

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

Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (please specify) _____			
Date of Birth ____/____/____			Alias Date of Birth ____/____/____		
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead		Date of Death ____/____/____		State of Death	
Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male-to-female (MTF) <input type="checkbox"/> Transgender female-to-male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional gender identity (specify) _____					
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown				Expanded Ethnicity	
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown				Expanded Race	

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

Address Event Type (check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Check if <u>SAME</u> as current address					
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary					
*Street Address					
City		County		State/Country	
*ZIP Code					

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

**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  Stage 3 (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 nonprescription drugs  Yes  No  Unknown

Received clotting factor for hemophilia/coagulation disorder  Yes  No  Unknown  
Specify clotting factor: \_\_\_\_\_ Date received \_\_\_/\_\_\_/\_\_\_\_\_

**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)  Yes  No  Unknown  
First date received \_\_\_/\_\_\_/\_\_\_\_\_ Last date received \_\_\_/\_\_\_/\_\_\_\_\_

Received transplant of tissue/organs or artificial insemination  Yes  No  Unknown

Worked in a healthcare or clinical laboratory setting  Yes  No  Unknown

If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: \_\_\_\_\_

Other documented risk (please include detail in Comments)  Yes  No  Unknown

**Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)**

**Suspect acute HIV infection?** *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*  Yes  No  Unknown

Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset \_\_\_/\_\_\_/\_\_\_\_\_  Yes  No  Unknown

Other evidence suggestive of acute HIV infection? *If YES, please describe:* \_\_\_\_\_ Date of evidence \_\_\_/\_\_\_/\_\_\_\_\_  Yes  No  Unknown

**Opportunistic Illnesses**

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 <sup>1</sup>	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary <sup>1</sup>	
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	

<sup>1</sup>If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

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

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 \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

Result  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test  
 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 \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test

**HIV Immunoassays (Differentiating)**

HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Role of test in diagnostic algorithm  
 Screening/initial test  Confirmatory/supplemental test  
 Result<sup>1</sup> Overall interpretation:  HIV-1 positive  HIV-2 positive  HIV positive, untypable  HIV-2 positive with HIV-1 cross-reactivity  
 HIV-1 indeterminate  HIV-2 indeterminate  HIV indeterminate  HIV negative  
 Analyte results: HIV-1 Ab:  Positive  Negative  Indeterminate Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test  
 HIV-2 Ab:  Positive  Negative  Indeterminate <sup>1</sup>Always complete the overall interpretation. Complete the analyte results when available.

HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result  Ag positive  Ab positive  Both (Ag and Ab positive)  Negative  Invalid  
 Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test

HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result<sup>2</sup> Overall interpretation:  Reactive  Nonreactive  Index value \_\_\_\_\_  
 Analyte results: HIV-1 Ag:  Reactive  Nonreactive  Not reportable due to high Ab level Index value \_\_\_\_\_  
 HIV-1 Ab:  Reactive  Nonreactive  Reactive undifferentiated Index value \_\_\_\_\_  
 HIV-2 Ab:  Reactive  Nonreactive  Reactive undifferentiated Index value \_\_\_\_\_  
 Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Point-of-care rapid test <sup>2</sup>Complete the overall interpretation and the analyte results.

**HIV Detection Tests (Qualitative)**

TEST  HIV-1 RNA/DNA NAAT (Qualitative)  HIV-1 culture  HIV-2 RNA/DNA NAAT (Qualitative)  HIV-2 culture  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result  Positive  Negative  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)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 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)  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Result  Detectable  Undetectable Copies/mL \_\_\_\_\_ Log \_\_\_\_\_ Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Drug Resistance Tests (Genotypic)**

TEST  HIV-1 Genotype (Unspecified) Test brand name/Manufacturer \_\_\_\_\_  
 Lab name \_\_\_\_\_ Facility name \_\_\_\_\_  
 Provider name \_\_\_\_\_ Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Immunologic Tests (CD4 count and percentage)**

CD4 at or closest to diagnosis: CD4 count \_\_\_\_\_ cells/ $\mu$ L CD4 percentage \_\_\_\_\_ % Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 First CD4 result <200 cells/ $\mu$ L or <14%: CD4 count \_\_\_\_\_ cells/ $\mu$ L CD4 percentage \_\_\_\_\_ % Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_  
 Other CD4 result: CD4 count \_\_\_\_\_ cells/ $\mu$ L CD4 percentage \_\_\_\_\_ % Collection Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Test brand name/Manufacturer \_\_\_\_\_ Lab name \_\_\_\_\_  
 Facility name \_\_\_\_\_ Provider name \_\_\_\_\_

**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 were positive for HIV-1: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.  
 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: \_\_\_\_\_

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

<b>Has this patient been informed of his/her HIV infection?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>This patient's partners will be notified about their HIV exposure and counseled by</b> <input type="checkbox"/> 1-Health dept <input type="checkbox"/> 2-Physician/Provider <input type="checkbox"/> 3-Patient <input type="checkbox"/> 9-Unknown	
<b>Evidence of receipt of HIV medical care other than laboratory test result</b> (select one; record additional evidence in Comments) <input type="checkbox"/> 1-Yes, documented <input type="checkbox"/> 2-Yes, client self-report, only Date of medical visit or prescription ___/___/_____			
<b>For Female Patient</b>			
<b>This patient is receiving or has been referred for gynecological or obstetrical services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Is this patient currently pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Has this patient delivered live-born infants?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>For Children of Patient</b> (record most recent birth in these boxes; record additional or multiple births in Comments)			
<b>*Child's Name</b>		<b>Child's Date of Birth</b> ___/___/_____	
<b>Child's Last Name Soundex</b>		<b>Child's State Number</b>	
<b>Facility Name of Birth</b> (if child was born at home, enter "home birth")		<b>*Phone</b> ( )	
<b>Facility Type</b> <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
<b>*Street Address</b>		<b>*ZIP Code</b>	
<b>City</b>	<b>County</b>	<b>State/Country</b>	

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

<b>Main source of antiretroviral (ARV) use information</b> (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			<b>Date patient reported information</b> ___/___/_____
<b>Ever taken any ARVs?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>If yes, reason for ARV use</b> (select all that apply)			
<input type="checkbox"/> HIV Tx	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PrEP	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PEP	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> PMTCT	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> HBV Tx	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____
<input type="checkbox"/> Other (specify reason) _____	ARV medications _____	Date began ___/___/_____	Date of last use ___/___/_____

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

<b>Main source of testing history information</b> (select one) <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review <input type="checkbox"/> Provider report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other			<b>Date patient reported information</b> ___/___/_____
<b>Ever had previous positive HIV test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Date of first positive HIV test</b> ___/___/_____	
<b>Ever had a negative HIV test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Date of last negative HIV test</b> (if date is from a lab test with test type, enter in Lab Data section) ___/___/_____	
<b>Number of negative HIV tests within the 24 months before the first positive test</b> ___ <input type="checkbox"/> Unknown			

**Comments**


**\*Local/Optional Fields**


This report to 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).