

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		*ZIP Code	
*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:		Screening, Diagnostic, Referral Agency:		Other Facility:	
<input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> Other, specify _____		<input type="checkbox"/> Private physician's office <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Other, specify _____		<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) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Check if <u>SAME</u> as facility providing information			
*Facility Name _____			*Phone () _____
*Street Address _____			
City _____	County _____	State/Country _____	*ZIP Code _____
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <i>Outpatient:</i> <input type="checkbox"/> Private physician's office <i>Screening, Diagnostic, Referral Agency:</i> <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Adult HIV clinic <input type="checkbox"/> CTS <input type="checkbox"/> STD clinic <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Other, specify _____			
*Provider Name _____		*Provider Phone () _____	Specialty _____

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

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

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

Suspect acute HIV infection? <i>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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other evidence suggestive of acute HIV infection? <i>If YES, please describe:</i> Date of evidence ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 ¹	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary ¹	
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	

¹If 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 _____

HIV Immunoassays (Differentiating)

HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)
 Role of test in diagnostic algorithm
 Screening/initial test Confirmatory/supplemental test
 Test brand name/Manufacturer _____ Lab name _____
 Facility name _____ Provider name _____

Result¹ 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 ¹Always 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 _____

Result² 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 ²Complete 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/ μ L CD4 percentage _____ % Collection Date ____/____/____
 Test brand name/Manufacturer _____ Lab name _____
 Facility name _____ Provider name _____

First CD4 result <200 cells/ μ L or <14%: CD4 count _____ cells/ μ L CD4 percentage _____ % Collection Date ____/____/____
 Test brand name/Manufacturer _____ Lab name _____
 Facility name _____ Provider name _____

Other CD4 result: CD4 count _____ cells/ μ 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)

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

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

Main source of antiretroviral (ARV) use information (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			Date patient reported information ___/___/_____
Ever taken any ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, reason for ARV use (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)

Main source of testing history information (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			Date patient reported information ___/___/_____
Ever had previous positive HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date of first positive HIV test ___/___/_____	
Ever had a negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 the 24 months before the first positive test ___ <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).