

DATE FORM COMPLETED:

Mo. Day Year

Mo.	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HIV/AIDS SURVEILLANCE PROGRAM
ADULT HIV CONFIDENTIAL CASE REPORT**

Patients ≥ 13 years of age at time of diagnosis
I. HEALTH DEPARTMENT USE ONLY

Lab Tracking #: _____

State Patient No.: _____

Source/Facility of Report:

II. FOR HIV REPORTING – REQUIRED COMPONENTS OF UNIQUE IDENTIFIER

First 2 letters Of Last Name	Number of Letters In Last Name	Gender		Month/Date/Year of Birth			Last 4 digits of Social Security Number							
		Male	Female	Month	Day	Year								
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

III. DEMOGRAPHIC INFORMATION

CURRENT STATUS: Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9	AGE AT DIAGNOSIS: HIV <input type="text"/> <input type="text"/> Years	DATE OF DEATH Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	STATE/TERRITORY OF DEATH: _____
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ETHNICITY: (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Specified <input type="checkbox"/> Not Hispanic or Latino	RACE: (check one or more) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Not Specified
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RESIDENCE AT DIAGNOSIS:
City: _____ State: _____ Zip Code: _____ Ward: _____ Country of Birth: _____

IV. FACILITY OF DIAGNOSIS

A. FACILITY OF HIV DIAGNOSIS

Facility Name: _____

City: _____ State/Country: _____

B. FACILITY TYPE (check one)

01 Physician, HMO 32 Hospital, Outpatient
 29 Community Health Center 88 Other (specify): _____
 30 Correctional Facility 99 Unknown
 31 Hospital, Inpatient

C. FACILITY SETTING (check one)

01 Public 03 Federal
 02 Private 09 Unknown

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Injected nonprescription drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Received clotting factor for hemophilia/coagulation disorder..... Specify <input type="checkbox"/> Factor VII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• HETEROSEXUAL relations with any of the following: • Intravenous/injection drug user.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Bisexual male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Person with hemophilia/coagulation disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Transfusion recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Transplant recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Person with AIDS or documented HIV infection, risk not specified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Received transfusion of blood/blood components (other than clotting factor).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Received transplant of tissue/organs or artificial insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Worked in a health-care or clinical laboratory setting..... (specify occupation): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other: Transgender (If yes check one): Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/>			

First Mo. Yr. Last Mo. Yr.

VI. LABORATORY

<p>1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)</p> <p>HIV-1 EIA..... <input type="checkbox"/> pos <input type="checkbox"/> neg <input type="checkbox"/> Ind <input type="checkbox"/> Not Done</p> <p>HIV-1 Western blot/IFA..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other HIV antibody test..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>HIV-2 antibody test..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>2. POSITIVE HIV DETECTION TEST: (Record earliest test)</p> <p>HIV PCR, DNA or RNA probe..... <input type="text"/> <input type="text"/></p> <p>Specify viral load: _____ (RNA copies/ml)</p> <p>Other (specify): _____</p>	<p>Date of last documented negative HIV test (specify type): _____ Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p> <p>If HIV laboratory test were not documented, is HIV Diagnosis documented by a physician?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.</p> <p>If yes, provide date of documentation by physician..... Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p>	
	<p>3. IMMUNOLOGIC LAB TESTS: (at or closest to current diagnostic status)</p> <p>CD4 Count..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cells/μL Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p> <p>CD4 Percent..... <input type="text"/> %</p> <p>First 200 μL or 14% CD4 Count..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cells/μL Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p> <p>CD4 Percent..... <input type="text"/> %</p>	
	<p>TEST DATE</p> <p>Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p> <p>Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p> <p>Mo. <input type="text"/> <input type="text"/> Yr. <input type="text"/> <input type="text"/></p>	

CLINICAL RECORD REVIEWED Yes No

Medical Record Number: _____

REASON FOR VISIT: (mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> SYMPTOMATIC FOR HIV/AIDS | <input type="checkbox"/> PRENATAL/JOB RELATED |
| <input type="checkbox"/> CLIENT REFERRAL | <input type="checkbox"/> COURT ORDERED |
| <input type="checkbox"/> PROVIDER REFERRAL | <input type="checkbox"/> TB RELATED |
| <input type="checkbox"/> STD RELATED | <input type="checkbox"/> OCCUPATIONAL EXPOSURE |
| <input type="checkbox"/> DRUG TRMT RELATED | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> FAMILY RELATED | |

ADDITIONAL RISK INFORMATION (mark all that apply)

- SEX WHILE USING NON-NU DRUGS
 SEX FOR DRUGSMONEY
 STD DIAGNOSIS

VII. TREATMENT/SERVICES REFERRALS

<p>Has this patient been informed of his/her HIV infection? Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/></p> <p>This patient's partners have been or will be notified about their exposure and counseled by: <input type="checkbox"/> Health Department <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown</p>	<p>This patient received or has been referred for: HIV Related medical services..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unk. *Substance abuse treatment services..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unk.</p>
<p>This patient received or is receiving: Anti-retroviral therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. *PCP prophylaxis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.</p>	<p>This patient's medical treatment is primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance/HMO <input type="checkbox"/> No Coverage <input type="checkbox"/> Other Public Funding <input type="checkbox"/> Clinical trial/government program <input type="checkbox"/> Unknown</p>

FOR WOMEN: -This patient is receiving or has been referred for gynecological or obstetrical services: Yes No Unknown # Of Other Births: _____
 -Is this patient currently pregnant?..... Yes No Unknown
 -Has this patient delivered live-born infant(s)? ... Yes No Unknown # Of Other Pregnancies: _____
 (If delivered after 1977, provide birth information below for the most recent birth)

CHILD'S DATE OF BIRTH

Mo.	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Hospital of Birth: _____
 City: _____ State: _____

VIII. COMMENTS: _____

HIV infection (without name) and AIDS cases (with name) are reportable to the District of Columbia Department of Health HIV/AIDS Surveillance Program, and only that program (Federal law - Section 308(d) of the Public Health Service Act (42 USC 242m))
CONFIDENTIAL MAILING ADDRESS: HPPC #14, 717 14th Street, NW, Box #5, Washington, DC 20005 FAX NO. (202) 724-5145
 Website: www.hivcounts.net

Physician/Provider's Name: _____ Phone No.: (____) _____
 Hospital/Facility: _____ Person Completing Form: _____ Phone No.: (____) _____
 Laboratory: _____

-Provider Identifier information is not transmitted to CDC-

Date Form Entered: Mo. Day Year

PHA/Investigators Initials: