HIV

COUNTY

FOR STATE USE ONLY
State Number
___/___/___ Date Form Completed

CASE IDENTIFICATION

Name _____ Phone(s) _____
Last First MI

Address _____
Street City Zip

E-mail _____Language _____

Social Security Number _____

☐OK to contact patient?

Orpheus Case ID _____

Provider _____

Reporter _____

Facility _____

Facility Phone _____

DEMOGRAPHICS

SEX ☐ Female ☐ Male ☐ Intersexed

GENDER ☐ Female ☐ Male
☐ MTF ☐ FTM ☐ Other _____

DOB ___/___/___

If DOB unknown, Age _____

COUNTRY OF BIRTH
☐ US
☐ Other _____

RACE (*check all that apply*)
☐ White ☐ American Indian/ Alaska Native
☐ Black ☐ Pacific Islander
☐ Asian ☐ Refused to answer
☐ Unknown ☐ _____

Hispanic ☐ Y ☐ N ☐ U

☐ HIV Infection (not AIDS)

☐ AIDS

Vital Status: ☐ Alive ☐ Dead ☐ Unknown

Date of death ___/___/___ State of death _____

CLINICAL BASIS OF DIAGNOSIS

Rapid
☐ P ☐ N date ___/___/___

HIV-1 EIA
☐ P ☐ N date ___/___/___

HIV-1/HIV-2 combination EIA
☐ P ☐ N date ___/___/___

HIV-1 Western Blot
☐ P ☐ N date ___/___/___

Positive HIV Detection Test

☐ Culture date ___/___/___

☐ PCR, DNA or RNA probe
date ___/___/___

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?

☐ Y ☐ N date ___/___/___

Date of last documented negative HIV test (specify type):_____
date ___/___/___

Viral load ever?
☐ Y ☐ N ☐ U
date 1st viral load ___/___/___
result _____

CD4 count ever
☐ Y ☐ N ☐ U
date 1st CD4 ___/___/___
result _____

CD4 percent ever
☐ Y ☐ N ☐ U
date 1st CD4 percent ___/___/___
result _____

CD4 count ever <200 or CD4 % <14
☐ Y ☐ N ☐ U
date ___/___/___
result _____

Current anti-retroviral therapy viral
☐ Y ☐ N ☐ U
approx start date ___/___/___

Receiving pneumocystis prophylaxis
☐ Y ☐ N ☐ U
approx start date ___/___/___

MISCELLANEOUS

Has the patient been informed of his/her HIV infection?
☐ Y ☐ N ☐ U date ___/___/___

This patient's partners will be notified about their HIV exposure and counseled by
☐ Health Department ☐ Physician/provider
☐ Patient ☐ Unknown

At the time of HIV diagnosis, medical treatment primarily reimbursed by:
_____ ☐ Uninsured

At the time of AIDS diagnosis, medical treatment primarily reimbursed by
_____ ☐ Uninsured

For female patients:
This patient is receiving or has been referred for gynecological or obstetrical services ☐ Y ☐ N ☐ U

Is this patient currently pregnant? ☐ Y ☐ N ☐ U

Has patient delivered live born infants ☐ Y ☐ N ☐ U
If yes, please list them:

Name DOB
_____
_____
_____

Orpheus Case ID Number

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Y	N	R	U	
☐	☐	☐	☐	Blood transfusion or transplant date ____/____/____
☐	☐	☐	☐	Sex ever with a male
☐	☐	☐	☐	Sex ever with a female
☐	☐	☐	☐	Sex ever with transgender
☐	☐	☐	☐	Anal or vaginal sex ever without a condom
☐	☐	☐	☐	Ever organ transplant or articifical insemination
☐	☐	☐	☐	Ever been a health care worker ***(if yes)***, specify _____
☐	☐	☐	☐	History of recreational injection drug use including intravenous injection or skin popping ***(check all that apply)*** ☐ Methamphemine/speed ☐ Heroin ☐ Speedball (heroin and cocaine together) ☐ Other _____
			☐	Ever shared syringes or needles with anyone

Y	N	R	U	
☐	☐	☐	☐	Hemophilia ***(check all that apply)*** ☐ Factor VII (Hemo A) ☐Factor IX (Hemo B) ☐ Other
☐	☐	☐	☐	***Heterosexual sex*** with injection drug user
☐	☐	☐	☐	***Heterosexual sex*** with bisexual men
☐	☐	☐	☐	***Heterosexual sex*** with a hemophiliac
☐	☐	☐	☐	***Heterosexual sex*** with transplant recipient
☐	☐	☐	☐	Sex with person HIV/AIDS ***(if yes)***

Partner infected by
- ☐ Unknown
- ☐ Refused
- ☐ Injection drug use
- ☐ Male parther had sex with men
- ☐ Male parther sex with men and IV drug use
- ☐ Female partner had previous positive partner
- ☐ Other_____

AIDS DEFINING CONDITIONS

Does patient have any AIDS-defining conditions such as: Esophageal candidiasis, Cytomegalovirus disease (other than in liver, spleen, or nodes), Cytomegalovirus retinitis (with loss of vision), Kaposi's sarcoma, Lymphoma, Burkitt's (or equivalent term), *Mycobacterium avium* complex or *M.kansasii*, disseminated or extrapulmonary *Mycobacterium,* of other species or unidentified species, disseminated or extrapulmonary, *Pneumocystis carinii* pneumonia, or Wasting syndrome due to HIV?

Disease name: _____ Date of diagnosis ____/____/____

Disease name: _____ Date of diagnosis ____/____/____

Disease name: _____ Date of diagnosis ____/____/____

Disease name: _____ Date of diagnosis ____/____/____

COMMENTS

ADMINISTRATION

Copy Orpheus Case Number to the top of this page.

Completed by _____ Phone _____

LHD completed case report ____/____/____

Provider Instructions for HIV Case Report Form

These instructions were developed as a tool to help collect case report information from health care providers. The Case Report Form can either be faxed to the provider and filled out by the provider or completed via a telephone interview with the provider or a staff member of the provider.

Form Field Details

County: Indicates Reporting County (filled out by reporting county.)

For State Use Only box: For State HIV staff to record case state number and date case was completed by state

Case Identification:

Name field: Fill in patient's last, first and middle name/initial.

Phone(s): Fill in the best phone number to reach the patient.

Address: Fill in the patient's complete street address

E-mail: Fill in the patient's e-mail address (if available)

Language: Please indicate the patient's preferred language

Social Security Number: Please provide the patient's SSN if available

Ok to contact patient?: Indicate if it is ok for the patient to be contacted by Public Health to offer partner services/service referral.

Orpheus Case ID Number: Please fill in the Patient's Orpheus Case number

Provider: Name of provider who diagnosed the case

Reporter: Name of person who filled in Case Report information

Facility: Name of facility where case was diagnosed or Case Report information was collected.

Facility Phone: Phone number for facility where case was diagnosed or Case Report information was collected.

Demographics:

Please fill in what is known about patient demographics at time of report

Clinical Basis of Diagnosis:

Testing history questions: Please fill in testing history that is known about the patient at time of report.

Anti-retroviral therapy and pneumocystis prophylaxis: If known, please record the approximate start dates, if applicable.

Miscellaneous:

Informed of diagnosis: Please record whether or not the patient has been informed of his/her HIV diagnosis and, if applicable, the date they were informed.

Method of partner notification: Please select the preferred method of partner notification.

Insurance: Please record the patient's primary insurance provider or indicate "uninsured."

Reproductive questions (women only): Please indicate whether the patient has been referred for gynecologic services, whether or not she is currently known to be pregnant and whether or not she has delivered any live-born children. If she has live-born children, please record their names and dates of birth (if known).

Possible Source s of Infection during Exposure Period:

If the patient's medical record or history indicates that he or she gave to the provider provides definitive information about any of the listed behaviors or exposures or related medical conditions, please record this. If the record has no information or patient history provides no information about the behavior, exposure or condition in question, leave the response boxes blank. "Unknown" means that you explicitly asked the patient and the patient said, "I don't know." "Refused" means that the patient was asked about the behavior, exposure, or condition but declined to answer. Please record all possible exposures that the patient has engaged in since 1978 or since their last negative HIV test.

AIDS Defining Conditions:

If patient is currently or ever has been diagnosed with an AIDS-defining opportunistic illness, please record the name of the illness and date of the diagnosis in this section. The form includes a list of the most frequent qualifying conditions.

Comments:

Please record any significant information about the patient that was not collected on the Case Report Form. Examples of this would be AKA names or DOBs, alternative phone numbers and/or addresses, if patient is hospitalized, if they may have diagnosed previously in another state, etc.

Administration:

(To be completed by County Public Health) Please put your name, phone number and date Case Report was completed in the areas provided