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 CDC

Centers for Disease Control and Prevention (CDC)

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

Form approved OMB no. 0920-0573 Exp. 02/28/2026

*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 ○ Military ○ Other ○ Postal ○ Shelter ○ Temporary

*Current Address, Street | Address Date (/ /)

*Phone | City | County | State/Country | *ZIP Code

*Medical Record Number | *Other ID Type | *Number

## II. 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

## III. 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

## IV. Patient Demographics (record all dates as mm/dd/yyyy)

Sex Assigned at Birth ○ Male ○ Female ○ Unknown

Country of Birth
○ US
○ Other/US dependency (specify)

Date of Birth (/ /) | Alias Date of Birth (/ /)

Vital Status
○ 1-Alive ○ 2-Dead

Date of Death (/ /) | State of Death

**Gender Identity**

- ○ Man
- ○ Woman
- ○ Transgender man
- ○ Transgender woman
- ○ Additional gender identity (specify) _____
- ○ Declined to answer
- ○ Unknown

**Date Identified** ___/___/___

**Sexual Orientation**

- ○ Straight or heterosexual
- ○ Lesbian or gay
- ○ Bisexual
- ○ Additional sexual orientation (specify) _____
- ○ Declined to answer
- ○ Unknown

**Date Identified** ___/___/___

**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** _____

## V. 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)

☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address

**Address Type**

- ○ Residential
- ○ Bad address
- ○ Correctional facility
- ○ Foster home
- ○ Homeless
- ○ Military
- ○ Other
- ○ Postal
- ○ Shelter
- ○ Temporary

***Street Address** _____

**City** _____ **County** _____

**State/Country** _____ ***ZIP Code** _____

## VI. 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** _____

## VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

☐ **Pediatric Risk (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<br>Specify clotting factor: _____ Date received ___/___/___ | ○ Yes | ○ No | ○ Unknown |

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, 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).

*After 1977 and before the earliest known diagnosis of HIV infection, this patient had:*

| HETEROSEXUAL relations with any of the following: | | | |
|---|---|---|---|
| HETEROSEXUAL contact with person who injected drugs | ○ 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 (include detail in Comments) | ○ Yes | ○ No | ○ Unknown |

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

**Acute HIV Infection**

| | | | |
|---|---|---|---|
| **Suspect acute HIV infection?** *If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result 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, describe:* _____ Date of evidence ____/____/____ | ○ Yes | ○ No | ○ Unknown |

**Opportunistic Illnesses**

| Diagnosis | Dx Date |
|---|---|
| Candidiasis, bronchi, trachea, or lungs | |
| Candidiasis, esophageal | |
| Carcinoma, invasive cervical | |
| Coccidioidomycosis, disseminated or extrapulmonary | |
| Cryptococcosis, extrapulmonary | |
| Cryptosporidiosis, chronic intestinal (>1 mo. duration) | |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) | |
| Cytomegalovirus retinitis (with loss of vision) | |
| HIV encephalopathy | |
| Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis | |
| Histoplasmosis, disseminated or extrapulmonary | |
| Isosporiasis, chronic intestinal (>1 mo. duration) | |
| Kaposi's sarcoma | |

| Diagnosis | Dx Date |
|---|---|
| Lymphoma, Burkitt's (or equivalent) | |
| Lymphoma, immunoblastic (or equivalent) | |
| Lymphoma, primary in brain | |
| Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary | |
| M. tuberculosis, pulmonary[1] | |
| M. tuberculosis, disseminated or extrapulmonary[1] | |
| Mycobacterium, of other/unidentified species, disseminated or extrapulmonary | |
| Pneumocystis pneumonia | |
| Pneumonia, recurrent, in 12 mo. period | |
| Progressive multifocal leukoencephalopathy | |
| Salmonella septicemia, recurrent | |
| Toxoplasmosis of brain, onset at >1 mo. of age | |
| Wasting syndrome due to HIV | |

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: _____

## IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

**HIV Immunoassays** **TEST** ○ HIV-1 IA ○ HIV-1/2 IA ○ HIV-1/2 Ag/Ab ○ HIV-2 IA

**Test Brand Name/Manufacturer** **Lab Name**

**Facility Name** **Provider Name**

**Result**
○ Positive
○ Negative
○ Indeterminate

**Collection Date**
____/____/____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ 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**
***Overall:***
○ Reactive
○ Nonreactive

***Analyte results:***
HIV-1 Ag:
○ Reactive
○ Nonreactive

HIV-1/2 Ab:
○ Reactive
○ Nonreactive

**Collection Date** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**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**[3]
***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** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ HIV-1/2 type differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)

**Test Brand Name/Manufacturer** | **Lab Name**

**Facility Name** | **Provider Name**

**Result**[4]
***Overall interpretation:***
○ HIV positive, untypable
○ HIV-1 positive with HIV-2 cross-reactivity
○ HIV-2 positive with HIV-1 cross-reactivity
○ HIV negative
○ HIV indeterminate
○ HIV-1 indeterminate
○ HIV-2 indeterminate
○ HIV-1 positive
○ HIV-2 positive

***Analyte results:***
HIV-1 Ab:
○ Positive
○ Negative
○ Indeterminate

HIV-2 Ab:
○ Positive
○ Negative
○ Indeterminate

**Collection Date** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ HIV-1 WB ○ HIV-1 IFA ○ HIV-2 WB

**Test Brand Name/Manufacturer** | **Lab Name**

**Facility Name** | **Provider Name**

**Result**
○ Positive
○ Negative
○ Indeterminate

**Collection Date** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

## HIV Detection Tests

**TEST** ○ HIV-1/2 RNA NAAT (Qualitative)

**Test Brand Name/Manufacturer** | **Lab Name**

**Facility Name** | **Provider Name**

**Result**
○ HIV-1
○ HIV-2
○ Both (HIV-1 and HIV-2)
○ HIV, not differentiated (HIV-1 or HIV-2)
○ Neither (negative)

**Collection Date** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ HIV-1 RNA NAAT (Qualitative and Quantitative)

**Test Brand Name/Manufacturer** | **Lab Name**

**Facility Name** | **Provider Name**

**Result**
***Qualitative:***
○ Reactive
○ Nonreactive

***Analyte results:***
HIV-1 Quantitative
○ Detectable above limit
○ Detectable within limits
○ Detectable below limit

**Copies/mL** _____

**Log** _____

**Collection Date** ___/___/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ HIV-1 RNA/DNA NAAT (Qualitative) ○ HIV-2 RNA/DNA NAAT (Qualitative) ○ HIV-1 culture ○ HIV-2 culture

**Test Brand Name/Manufacturer** **Lab Name**

**Facility Name** **Provider Name**

**Result**
○ Positive
○ Negative
○ Indeterminate

**Collection Date** ____/____/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

**TEST** ○ HIV-1 RNA/DNA NAAT (Quantitative) ○ HIV-2 RNA/DNA NAAT (Quantitative)

**Test Brand Name/Manufacturer** **Lab Name**

**Facility Name** **Provider Name**

**Result**
○ Detectable above limit
○ Detectable within limits
○ Detectable below limit
○ Not detected

**Copies/mL** _____

**Log** _____

**Collection Date** ____/____/_____

**Testing Option** (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

## 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 count** _____ **cells/µL** **CD4 percentage** _____ **%** **Collection Date** ____/____/_____

**Test Brand Name/Manufacturer** **Lab Name**

**Facility Name** **Provider Name**

## Documentation of Tests

*Complete only if none of the following were positive for **HIV-1**: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

**Did documented laboratory test results meet approved HIV diagnostic algorithm criteria?** ○ Yes ○ No ○ Unknown

**If YES, provide specimen collection date of earliest positive test result for this algorithm** ____/____/_____

**Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results?** ○ Yes ○ No ○ Unknown

**If YES, provide date of diagnosis by physician** ____/____/_____

**Date of last documented negative HIV test result** (before HIV diagnosis date) ____/____/_____

**Specify type of test:** _____

**Testing Option** (if applicable)
○ Point-of-care test by provider ○ Self-test, result directly observed by a provider[2] ○ Lab test, self-collected sample

[2] Results not directly observed by a provider should be recorded in HIV Testing History. [3] Complete the overall interpretation and the analyte results. [4] Always complete the overall interpretation. Complete the analyte results when available.

# X. 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

**Evidence of receipt of HIV medical care other than laboratory test result**
(select one; record additional evidence in Comments)
○ 1-Yes, documented ○ 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**
○ 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 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**

*Inpatient:* ○ Hospital ○ Other, specify

*Outpatient:* ○ Other, specify

*Other Facility:* ○ Emergency room ○ Corrections ○ Unknown ○ Other, specify

***Street Address** | **City**

**County** | **State/Country** | ***ZIP Code**

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

**Main source of antiretroviral (ARV) use information** (select one)
○ Patient interview ○ Provider report ○ Other
○ Medical record review ○ NHM&E

**Date patient reported information** ___/___/___

**Ever taken any ARVs?** ○ Yes ○ No ○ Unknown

**If yes, reason for ARV use** (select all that apply)

| | ARV medications | Date began | Date of last use |
|---|---|---|---|
| ☐ HIV Tx | | ___/___/___ | ___/___/___ |
| ☐ PrEP | | ___/___/___ | ___/___/___ |
| ☐ PEP | | ___/___/___ | ___/___/___ |
| ☐ PMTCT | | ___/___/___ | ___/___/___ |
| ☐ HBV Tx | | ___/___/___ | ___/___/___ |
| ☐ Other (specify reason) | | ___/___/___ | ___/___/___ |

## XII. 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 result?** ○ Yes ○ No ○ Unknown

**Date of first positive HIV test result** ___/___/___

**Was the first positive test result from a self-test performed by the patient?** ○ Yes ○ No ○ Unknown

**Ever had a negative HIV test result?** ○ Yes ○ No ○ Unknown

**Date of last negative HIV test result** ___/___/___
*(if date is from a lab test with test type, enter in Lab Data section)*

**Was the last negative test result from a self-test performed by the patient?** ○ Yes ○ No ○ Unknown

**Number of negative HIV test results within the 24 months before the first positive test result** _____ ☐ Unknown

**How many of these negative test results were from self-tests performed by the patient?** _____ ☐ Unknown

## XIII. Comments

☐ **CHECK OOS STATE:** _____

**If pregnant, list EDD (due date): ___/___/___**

☐ **DOC#**

**Link with e-HARS stateno(s):**

## XIV. *Local/Optional Fields

NIR Status:

STARS# _____
DOC:_____
Other Risks: A☐ B/C ☐ D ☐ F ☐ M ☐ V ☐ J ☐ O☐
Hepatitis: A ☐ B ☐ C ☐ Other ☐ UNKnown ☐
Test and Treat (Yes/No):

**NIR OP** ☐ **Date:** ___/___/___
**NIR CL** ☐ **Date:** ___/___/___
**NIR RE** ☐ **Date:** ___/___/___
**Initials(3)** _____ **Source code:** _____