NC Department of Health and Human Services

ADULT HIV / AIDS CONFIDENTIAL CASE REPORT FORM

(PATIENTS ≥ 13 YEARS OF AGE AT TIME OF DIAGNOSIS)

North Carolina Public Health

State / Regional Use Only

Date Report Received __ __ / __ __ / __ __ __ __

ID Type: _____ **ID** __ __ __ __ __ __ __ __ __ __

Patient Identification / Demographics

Patient First Name	Middle Name	Last Name	Suffix

Maiden Name	Alias Name

Current Street Address	Phone □ Home □ Mobile □ Work

City	County	State/Country	ZIP Code

Birth Date __ __ / __ __ / __ __ __ __	Gender □ Male □ Female	Social Security Number

Transgender □ Transgender Male-to-Female (MTF) □ Transgender Female-To-Male (FTM) □ Not Applicable

Marital Status □ Single, Never Married □ Married □ Separated □ Divorced □ Widow □ Other □ Unknown

Country of Birth □ US □ Other/ US Dependency (please specify)

Race (check all that apply) □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ White □ Unknown

Hispanic Ethnicity □ Yes □ No □ Unknown

Vital Status	Death Date	State of Death
□ Alive □ Dead	__ __ / __ __ / __ __ __ __	

Facility Providing Information

Source of this Report Information

Inpatient:
□ Hospital / Acute Care Facility
□ Long Term Care Facility
□ Other, specify _____

Outpatient:
□ Private Physician's Office
□ Adult HIV Clinic
□ Infectious Disease Clinic
□ Other, specify _____

Screening, Diagnostic, Referral Agency:
□ Blood Bank
□ HIV Counseling & Testing Site
□ STD Clinic
□ Other, specify _____

Other Facility:
□ Emergency Room
□ Corrections
□ Other, specify _____

Date this Form Completed __ __ / __ __ / __ __ __ __	Reporting Facility/Practice Name

Street Address	Phone

City	County	State/Country	Zip Code

Patient Health Care Provider Name	Provider Phone

Medical Record Number	Alt Contact / Person Completing Form	Phone

HIV Diagnosis Information

Facility of HIV Diagnosis

Is the facility of HIV diagnosis the same as the reporting facility? □ Yes □ No (If yes, leave facility fields blank)

Facility Name	Phone

Street Address

City	County	State/Country	Zip Code

Laboratory Data (record additional tests in Comments section)

Test Type: HIV-1 Western Blot	**Result:** □ Positive/Reactive □ Negative/Nonreactive □ Indeterminate	**Collection Date:** __ __ / __ __ / __ __ __ __
Test Type: HIV-1RNA/DNA NAAT (Qualitative)	**Result:** □ Positive/Reactive □ Negative/Nonreactive □ Not Specified	**Collection Date:** __ __ / __ __ / __ __ __ __
Test Type: HIV-1 RNA/DNA NAAT (Quantitative)	**Result:** □ Below Limit □ Within Limit □ Above Limit **Copies/mL:** _____ **Log:** _____	**Collection Date:** __ __ / __ __ / __ __ __ __
Test Type: CD4	**Count:** **CD4 percentage:**	**Collection Date:** __ __ / __ __ / __ __ __ __

If no laboratory tests are available, did the physician document HIV infection? □ Yes □ No

If YES, provide date of documentation by Physician: __ __ / __ __ / __ __ __ __

Signs & Symptoms:

Residence at HIV Diagnosis

Is the residence at HIV diagnosis the same as the current address? □ Yes □ No (If yes, leave residence fields blank)

Street Address			
City	**County**	**State/Country**	**ZIP Code**

AIDS Diagnosis Information

Facility of AIDS Diagnosis

Is the facility of AIDS diagnosis the same as the reporting facility? □ Yes □ No (If yes, leave facility fields blank)

Facility Name	**Phone**
Street Address	

City	**County**	**State/Country**	**Zip Code**

Laboratory Data (record additional tests in Comments section)

Test Type: CD4	**Count:**	**CD4 percentage:**	**Collection Date:** __ __ / __ __ / __ __ __ __

Residence at AIDS Diagnosis

Is the residence at AIDS diagnosis the same as the current address? □ Yes □ No (If yes, leave residence fields blank)

Street Address			
City	**County**	**State/Country**	**ZIP Code**

Clinical (select D for Definitive or P for Presumptive where applicable) (record all dates as mm/dd/yyyy)

	D	P	Date		D	P	Date		D	P	Date
Candidiasis, bronchi, trachea, or lungs				Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				M. tuberculosis, pulmonary*			
Candidiasis, esophageal				Histoplasmosis, disseminated or extrapulmonary				M. tuberculosis, disseminated or extrapulmonary*			
Carcinoma, invasive cervical				Isosporiasis, chronic intestinal (>1 mo. duration)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
Coccidiodomycosis, disseminated or extrapulmonary				Kaposi's sarcoma				Pneumocystis carinii 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			

*If TB selected above, indicate RVCT Case Number:

Patient History (respond to all questions) □ Pediatric risk (please enter in Comments)

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

Ever used Injection Drugs? □ Yes □ No □ Unknown

Sex with male		Sex with female	
	□ Yes □ No □ Unknown		□ Yes □ No □ Unknown
Male partner injects drugs	□ Yes □ No □ Unknown	Female partner injects drugs	□ Yes □ No □ Unknown
Male partner is a transfusion recipient with documented HIV	□ Yes □ No □ Unknown	Female partner is a transfusion recipient with documented HIV	□ Yes □ No □ Unknown
Male partner is a transplant recipient with documented HIV	□ Yes □ No □ Unknown	Female partner is a transplant recipient with documented HIV	□ Yes □ No □ Unknown
Male partner has hemophilia/coagulation disorder	□ Yes □ No □ Unknown	Female partner has hemophilia/coagulation disorder	□ Yes □ No □ Unknown
Male partner has documented HIV infection or AIDS	□ Yes □ No □ Unknown	Female partner has documented HIV infection or AIDS	□ Yes □ No □ Unknown
Male partner has sex with other men (MSM) or bisexual	□ Yes □ No □ Unknown	Female partner is at risk for HIV/AIDS	□ Yes □ No □ Unknown
Male partner is at risk for HIV/AIDS	□ Yes □ No □ Unknown		

Does patient have any other documented risk (please specify): □ Yes □ No □ Unknown

Does the patient have no acknowledged risk for this disease? □ Yes □ No □ Unknown

Patient History - continued

Health Care Facility – Blood and Body Fluid Exposure

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)	☐ Yes ☐ No ☐ Unknown
First date received __ __ / __ __ / __ __ __ __ Last date received __ __ / __ __ / __ __ __ __	
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received (mm/dd/yyyy): __ __ / __ __ / __ __ __ __	☐ Yes ☐ No ☐ Unknown
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:	

Patient Recall of HIV Testing History

Date of clinic visit __ __ / __ __ / __ __ __ __	Reason for Testing
Patient reports previous positive HIV test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Patient reported date of first positive HIV test: __ __ / __ __ / __ __ __ __
Patient reports previous negative HIV test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Patient reported 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 24 months before first positive test # _____ ☐ Refused ☐ Don't Know/Unknown	

Screening, Counseling, and Referrals

Was this patient tested for TB?	Date of Test __ __ / __ __ / __ __ __ __	Test Result:
Was this patient tested for syphilis?	Date of Test __ __ / __ __ / __ __ __ __	Test Result:
Was this patient post test counseled for HIV? ☐ Yes ☐ No ☐ Results Pending ☐ Unknown	Date post test counseled for HIV __ __ / __ __ / __ __ __ __	
HIV post test counseling provider	HIV post test counseled location	
Has this patient been informed of his/her HIV status? ☐ Yes ☐ No ☐ Unknown	This patient's partners will be notified about their HIV exposure and counseled by: ☐ Health Dept ☐ Physician/Provider ☐ Patient ☐ Unknown	
Were referrals made? ☐ Yes ☐ No	If yes, referral type: ☐ Social Services ☐ Substance Abuse ☐ HIV Case Management ☐ Primary Medical Services ☐ ID Specialist ☐ Mental Health ☐ Other, specify _____	
Referral Facility Name:	Referral Date: __ __ / __ __ / __ __ __ __	

Treatment

Patient ever taken any antiretrovirals (ARVs) for HIV prevention? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, ARV medications:	
Dates ARVs taken	Date first began: __ __ / __ __ / __ __ __ __	Date of last use: __ __ / __ __ / __ __ __ __
Patient ever taken any antiretrovirals (ARVs) for HIV Treatment? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, ARV medications:	
Dates ARVs taken	Date first began: __ __ / __ __ / __ __ __ __	Date of last use: __ __ / __ __ / __ __ __ __

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 the Comments section)

Child's Name	Child Soundex *(state use only)*	Child's Date of Birth __ __ / __ __ / __ __ __ __
Child's Coded ID *(state use only)*	Child's State Number *(state use only)*	

Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name	Phone	Zip Code	
Street Address	City	County	State/Country

Comments

Instructions for Completing the Form

This form should be completed whenever a physician/clinician professionally treats or provides consultation for an HIV diagnosis as defined by G.S. 103A-135. The patient may not necessarily be a new infection. Please answer all applicable questions; if the response is "unknown", please indicate so. A blank response is assumed to mean the question was overlooked. The completed form is for state and local health department use only and is **not** sent to the CDC.

Patient Identification/Demographics: Complete the entire section. Please be sure to include vital status, race, ethnicity, and country of birth. Valid race and ethnicity information is needed for morbidity to be officially counted.

Facility Providing Information: *Reporting Facility/Practice Name* represents the agency (hospital, clinic, health department, etc.) that **is** completing this case report form as required under G.S. 103A-135. *Patient Health Care Provider Name* represents the physician/clinician seeing the patient at this reporting facility. Please provide the name of the *Person Completing Form* who can be consulted for additional information or questions about the information provided on this form.

Facility of HIV Diagnosis: This represents the facility that ordered the diagnostic test that confirmed HIV infection for this patient. This is usually the same facility that is completing this case report form and may not represent the earliest diagnosis for the patient. The documented diagnostic information provided in the laboratory data section should be available at the facility completing this report.

Laboratory Data (HIV): Please complete the HIV related laboratory tests result for the patient. This should include the HIV diagnostic tests and any additional test performed to assess the patient's disease status. If no diagnostic tests were performed at the reporting facility to confirm HIV infection, please complete the date the HIV diagnosis was confirmed via consultation with the diagnosing/referring facility or physician in "*If no laboratory test are available, did the physician document HIV infection?* section. Patient's recall of earlier test results (undocumented) should be entered in the *Patient Recall of HIV Testing History* section on page 3.

Residence at HIV Diagnosis: This represents the patient's address at the time the HIV diagnostic tests (reported on this form) were performed.

Facility of AIDS Diagnosis: This represents the facility that ordered the test that confirmed AIDS diagnosis for this patient. This is usually the same facility that is completing this case report form.

Laboratory Data (AIDS): Please complete the AIDS related (CD4) laboratory tests result for the patient.

Residence at AIDS Diagnosis: This represents the patient's address at the time the AIDS diagnostic tests (reported on this form) were performed.

Clinical: Please complete the AIDS related opportunistic infection/diagnosis result for the patient.

Patient History: This section represents risk activities for the patient. This information is very important to understanding changes in the disease epidemiology. Please answer all questions. A separate set of questions is provided for sexual activities with partners of each gender. *Health Care Facility* risks should be completed only for patients that are suspected of acquiring HIV via a health care event. Please complete the information for the specific activities suspected.

Patient Recall of HIV Testing History: Please complete this section with information about whether the patient indicated earlier HIV testing. Please include the estimated dates if exact dates are not known.

Screening, Counseling and Referrals: Please indicate any screening results for TB or syphilis. Documented TB diagnoses should be included in the *Clinical* section. Please enter any post test counseling and referral information as appropriate.

Treatment: Indicate any antiretrovirals (ARV) taken including any indicated by patient recall/history.

For Female Patient: Indicate current pregnancy information.

Comments: Please indicate any additional information here that would be helpful for patient follow up. If the patient indicated a previous diagnosis (out-of-state or in-state) please indicate approximate date and location here.