HIV/AIDS Surveillance Program
3441 Forbes Avenue
Pittsburgh, PA 15213
Phone: 412.578.8332 FAX: 412.578.8300

Reporting HIV+ Adult Cases by Name

Procedure for Completing the ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

This document provides instructions for filling out the ***ADULT HIV/AIDS CONFIDENTIAL CASE REPORT.***

Effective June 1, 2001, HIV is a notifiable disease reportable directly to the Allegheny County Health Department (ACHD). ***Article V., REPORTING OF HIV*** requires that all health care facilities report HIV infection. A Health Care Facility is defined as., "a general or special hospital including tuberculosis and psychiatric hospitals; rehabilitation facilities; skilled nursing facilities; kidney disease treatment centers; including freestanding hemodialysis units; intermediate care facilities and ambulatory surgical facilities, both profit and non-profit, and including those operated by any agency of the State or local government; and any other facility that tests for the presence of HIV."

The following is a description of all the information that is needed to complete the **ADULT HIV/AIDS CONFIDENTIAL CASE REPORT.** Please fill in the form as completely as possible. ACHD Surveillance program staff may contact you by person or by phone to verify, or add to, the information provided.

I. PATIENT'S NAME AND ADDRESS

Enter the patient's name, address, and zip code. This is the patient's principle or current place of residence.

II. (HEALTH DEPARTMENT USE ONLY)

Do not complete this section.

III. DEMOGRAPHIC INFORMATION

Please complete all sections.

IV. FACILITY OF DIAGNOSIS

This information applies to the health care facility that is reporting the HIV+ test.

V. PATIENT HISTORY

Please indicate the risk factor/factors that were given to the counselor during the initial pre-test counseling session. OR, indicate the risk factor/factors that the patient engaged in to become infected with HIV.

VI. LABORATORY DATA

Fill in the relevant laboratory data if it is known. Please be sure to record the detectable viral load and CD4 test results if they were done. If this data is unknown, an ACHD Surveillance staff member may call you or visit your health care facility to obtain this information.

VII. PHYSICIAN'S INFORMATION

Please enter the Physician's information as well as the name and phone number of the person completing this form.

VIII. CLINICAL STATUS

This refers to AIDS defining conditions. If any of these indicator diseases are present then this is an AIDS case and should be noted as such in SECTION III.

IX. TREATMENT/SERVICES REFERRALS

Fill out this section completely. It is the responsibility of the health care facility to insure that the patient is receiving appropriate medical care for their HIV infection. If the health care facility does not provide medical care, it is the agency's responsibility to insure the patient has been referred to a medical facility that provides care for HIV disease.

X. COMMENTS

Add comments if you wish.

> ***NOTE:* PATIENTS <13 YEARS OF AGE (PEDIATRIC)**
> **ARE NOT REPORTED USING THIS ADULT FORM.**
> ***CALL 578-8358 FOR THE PEDIATRIC REPORTING FORM*.**

Once the form is completed, please mail it in an envelope marked **"confidential"** to:

Allegheny County Health Department
HIV/AIDS Surveillance Program
3441 Forbes Avenue
Pittsburgh, PA 15213

If you have any questions regarding this form please call 412.578.8358.

I. STATE/LOCAL USE ONLY

Patient's Name: ____________ (Last, First, M.I.) Phone No.: ( ) ____________

Address: ____________ City: ____________ County: ____________ State: ____________ Zip Code: ____________

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

– Patient identifier information is not transmitted to CDC! –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved OMB No. 0920-0009

DATE FORM COMPLETED: Mo. ☐☐ Day ☐☐ Yr. ☐☐

REPORT SOURCE: ☐☐

II. HEALTH DEPARTMENT USE ONLY

SOUNDEX CODE:	REPORT STATUS:	REPORTING HEALTH DEPARTMENT:	
☐☐☐☐	1 New Report 2 Update	State: ____________ City/County: ____________	State Patient No.: ☐☐☐☐☐☐☐☐☐☐ City/County Patient No.: ☐☐☐☐☐☐☐☐☐☐

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one):
- 1 HIV Infection (not AIDS)
- 2 AIDS

AGE AT DIAGNOSIS: ☐☐ Years / ☐☐ Years

DATE OF BIRTH: Mo. ☐☐ Day ☐☐ Yr. ☐☐

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Mo. ☐☐ Day ☐☐ Yr. ☐☐

STATE/TERRITORY OF DEATH: ____________

SEX:
- 1 Male
- 2 Female

RACE/ETHNICITY:
- 1 White (not Hispanic)
- 2 Black (not Hispanic)
- 3 Hispanic
- 4 Asian/Pacific Islander
- 5 American Indian/ Alaska Native
- 9 Not Specified

COUNTRY OF BIRTH:
- 1 U.S.
- 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): ____________
- 8 Other (specify): ____________
- 9 Unknown

RESIDENCE AT DIAGNOSIS:

City: ____________ County: ____________ State/ Country: ____________ Zip Code: ☐☐☐☐☐☐☐☐☐

IV. FACILITY OF DIAGNOSIS

Facility Name ____________

City ____________

State/Country ____________

FACILITY SETTING (check one)
- 1 Public
- 2 Private
- 3 Federal
- 9 Unk.

FACILITY TYPE (check one)
- 01 Physician, HMO
- 31 Hospital, Inpatient
- 88 Other (specify): ____________

This report to the Centers for Disease Control and Prevention (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/AIDS. Information in CDC's HIV/AIDS 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).

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	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify): ____________

• *HETEROSEXUAL* relations with any of the following:

	Yes	No	Unk.
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9

First Mo. ☐☐ Yr. ☐☐ Last Mo. ☐☐ Yr. ☐☐

	Yes	No	Unk.
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9

(specify occupation): ____________

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo.	Yr.
• HIV–1 EIA	1	0	–	9	☐☐	☐☐
• HIV–1/HIV–2 combination EIA	1	0	–	9	☐☐	☐☐
• HIV–1 Western blot/IFA	1	0	8	9	☐☐	☐☐
• Other HIV antibody test	1	0	8	9	☐☐	☐☐

(specify): ____________

2. POSITIVE HIV DETECTION TEST: (Record earliest test)

☐ culture ☐ antigen ☐ PCR, DNA or RNA probe — Mo. ☐☐ Yr. ☐☐

• Other (specify): ____________ Mo. ☐☐ Yr. ☐☐

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* ☐☐ COPIES/ML ☐,☐☐☐,☐☐☐ Mo. ☐☐ Yr. ☐☐

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

• Date of last documented negative HIV test (specify type): ____________ Mo. ☐☐ Yr. ☐☐

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 No 0 Unk. 9

If yes, provide date of documentation by physician Mo. ☐☐ Yr. ☐☐

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

- • CD4 Count ☐,☐☐☐ cells/μL Mo. ☐☐ Yr. ☐☐
- • CD4 Percent ☐☐ % Mo. ☐☐ Yr. ☐☐

First <200 μL or <14%

- • CD4 Count ☐,☐☐☐ cells/μL Mo. ☐☐ Yr. ☐☐
- • CD4 Percent ☐☐ % Mo. ☐☐ Yr. ☐☐

VII. STATE/LOCAL USE ONLY

Physician's Name: ______ Phone No.: ( ) ______ Medical Record No. ______
(Last, First, M.I.)

Hospital/Facility: ______ Person Completing Form: ______ Phone No.: ( ) ______

– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. [ ] Yr. [ ] Symptomatic (not AIDS): Mo. [ ] Yr. [ ]

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Candidiasis, bronchi, trachea, or lungs	1	NA			Lymphoma, Burkitt's (or equivalent term)	1	NA		
Candidiasis, esophageal	1	2			Lymphoma, immunoblastic (or equivalent term)	1	NA		
Carcinoma, invasive cervical	1	NA			Lymphoma, primary in brain	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA			*Mycobacterium avium* complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
Cryptococcosis, extrapulmonary	1	NA			*M. tuberculosis*, pulmonary*	1	2		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA			*M. tuberculosis*, disseminated or extrapulmonary*	1	2		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			*Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Cytomegalovirus retinitis (with loss of vision)	1	2			*Pneumocystis carinii* pneumonia	1	2		
HIV encephalopathy	1	NA			Pneumonia, recurrent, in 12 mo. period	1	2		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			Progressive multifocal leukoencephalopathy	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA			Salmonella septicemia, recurrent	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			Toxoplasmosis of brain	1	2		
Kaposi's sarcoma	1	2			Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.: [ ]

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

	Yes	No	NA	Unk.
• HIV related medical services	1	0	–	9
• Substance abuse treatment services	1	0	8	9

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	1	0	9
• PCP prophylaxis	1	0	9

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

FOR WOMEN:
- This patient is receiving or has been referred for gynecological or obstetrical services: .... [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? .... [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? .... [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

CHILD'S DATE OF BIRTH: Mo. [ ] Day [ ] Yr. [ ]

Hospital of Birth: ______
City: ______ State: ______

Child's Soundex: [ ]

Child's State Patient No. [ ]

X. COMMENTS: ______

Public reporting burden of this collection of information is estimated to average 10 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-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). **Do not send the completed form to this address.**