

ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

| |
|---------------------|
| Date Form Received: |
|---------------------|

I. Health Department/Reporting Facility Use (Record All Dates as mm/dd/yyyy)

*** Required Sections/Fields.**

| | | | |
|---|---|--|---------|
| *Name of Person Completing Form: | *Person's Phone Number: () | *STATENO: | CITYNO: |
| *Date Form Completed: ____/____/____ | *Reporting Health Department - City/County: | *Document Source: | |
| Physician's Name: | Physician's Phone Number: () | Hospital/Facility Name: | |
| Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Surveillance Method: <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow Up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown | Report Medium: <input type="checkbox"/> 1- Field Visit <input type="checkbox"/> 2- Mailed <input type="checkbox"/> 3- Phone <input type="checkbox"/> 4- Electronic Transfer <input type="checkbox"/> 5- CD/Disk | |

II. Patient Identification

| | | |
|--|--------------------------|-----------------------------|
| *Patient Last Name: | *Middle Name: | *First Name: |
| Alternate Name Type (e.g. Alias, Married, etc.): | Last Name: | Middle Name: First Name: |
| *Address Type: <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary | | |
| *Current Street Address: | *City: | *County: |
| *State/Country: | *ZIP Code: | *Phone Number: () |
| Other ID Type #1: | *Social Security Number: | Other ID Type #2: |
| Other ID Type #1 Number: | Other ID Type #2: | Other ID Type #2 Number: |

III. Patient Demographics (Record All Dates as mm/dd/yyyy)

| | | |
|---|---|---|
| *Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown | Country of Birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other/U.S. Dependency (please specify): _____ | *Date of Birth: ____/____/____ |
| Alias Date of Birth: ____/____/____ | *Vital Status: <input type="checkbox"/> 1- Alive <input type="checkbox"/> 2- Dead | Date of Death: ____/____/____ |
| State of Death: | | *Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS |
| Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender: Male-to-Female (MTF) <input type="checkbox"/> Transgender: Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Other Gender Identity (specify): _____ | | *Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Cambodian <input type="checkbox"/> Other (specify): _____ |
| *Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown | Expanded Ethnicity: | |
| Expanded Race: | | |

IV. *Residence at Diagnosis (Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)

| | | | | |
|---|-----------------|-------|---------|-----------------------------|
| Address Type (check all that apply): <input type="checkbox"/> Residence at HIV Diagnosis <input type="checkbox"/> Residence at AIDS Diagnosis <input type="checkbox"/> Check if SAME as Current Address | | | | |
| Address of Residence at HIV Diagnosis | Street Address: | City: | County: | State/Country: ZIP Code: |
| Address of Residence at AIDS Diagnosis | Street Address: | City: | County: | State/Country: ZIP Code: |

V. *Facility at Diagnosis (Add Additional Facilities in Comments and Local/Optional Fields Section) **STATENO:** _____ **MEDREC# / ID:** _____

| | | | |
|--|--|-----------------|----------------|
| Diagnosis Type (check all that apply to facility): <input type="checkbox"/> HIV Diagnosis <input type="checkbox"/> AIDS Diagnosis <input type="checkbox"/> Check if SAME as Facility Providing Information | | | |
| Facility Name: | Phone Number: () | Street Address: | City: |
| County: | State/Country: | ZIP Code: | Provider Name: |
| Facility Type: | <u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____ | | |
| | <u>Outpatient:</u> <input type="checkbox"/> Private Physician <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other (specify): _____ | | |
| | <u>Screening, Diagnostic, Referral Agency:</u> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other (specify): _____ | | |
| | <u>Other Facility:</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____ | | |

VI. *Patient History (Respond to All Questions) **Pediatric Risk** (Please Enter in Comments and Local/Optional Fields Section)

| | | |
|--|--|--|
| After 1977 and before the earliest known diagnosis of HIV infection, this patient had: | | |
| Sex with a male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Sex with a female: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Injected non-prescription drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| HETEROSEXUAL relations with any of the following: | Has the patient: | |
| Contact with intravenous/injection drug user (IDU): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Received clotting factor for hemophilia/coagulation disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| Contact with a bisexual male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Received transfusion of blood/blood components (non-clotting): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| Contact with a person with AIDS or documented HIV infection, risk not specified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Other documented risk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| Contact with transplant recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | (if yes, specify): _____ | |
| Contact with transfusion recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | _____ | |

VII. *Laboratory Data (Record All Dates as mm/dd/yyyy) (See Instructions for Details)

| | | |
|--|---|---------------------------------|
| HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2] | | |
| TEST 1: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____ | | |
| RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____ | RAPID TEST (check if rapid): <input type="checkbox"/> | Collection Date: ____/____/____ |
| TEST 2: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____ | | |
| RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____ | RAPID TEST (check if rapid): <input type="checkbox"/> | Collection Date: ____/____/____ |
| TEST 3: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____ | | |
| RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____ | RAPID TEST (check if rapid): <input type="checkbox"/> | Collection Date: ____/____/____ |
| HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2] | | |
| TEST: <input type="checkbox"/> HIV-1/2 Differentiating (e.g. Multispot) | | |
| RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) Collection Date: ____/____/____ | | |

VII. *Laboratory Data (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____ MEDREC# / ID: _____

| | | |
|--|--|--|
| HIV Detection Tests (Qualitative) | | |
| TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture | | |
| RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate | | Collection Date: ____/____/____ |
| TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture | | |
| RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate | | Collection Date: ____/____/____ |
| HIV Detection Tests (Quantitative Viral Load) <i>Note: Include earliest test after diagnosis</i> | | |
| TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____ | | |
| RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ | | Log: _____ Collection Date: ____/____/____ |
| TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____ | | |
| RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ | | Log: _____ Collection Date: ____/____/____ |
| Immunologic Tests (CD4 Count and Percentage) | | |
| CD4 at or closest to current diagnosis status: CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____ | | |
| First CD4 result <200 cells/μL or <14%: CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____ | | |
| Other CD4 result <200 cells/μL or <14%: CD4 count: _____ cells/μL CD4 percentage: _____ % Collection Date: ____/____/____ | | |
| Documentation of Tests (Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]) | | |
| Did documented laboratory test results meet approved HIV diagnostic algorithm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| If yes, provide date (specimen collection date if known) of earliest positive test for this algorithm: ____/____/____ | | |
| If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| If yes, provide date of documentation by physician: ____/____/____ | | |

VIII. Clinical (Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)

| | ✓ | Date | | ✓ | Date |
|--|---|------|--------------------------------|---|------|
| Candidiasis, esophageal | | | Kaposi's sarcoma | | |
| Cryptococcosis, extrapulmonary | | | Pneumocystis carinii pneumonia | | |
| Cytomegalovirus disease (other than in liver, spleen or nodes) | | | Wasting syndrome due to HIV | | |
| Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis | | | Other (specify): | | |

IX. Treatment/Services Referrals (Record All Dates as mm/dd/yyyy)

| | |
|--|---|
| Has This Patient Been Informed of His/Her HIV Infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| Patient's Medical Treatment is Primarily Reimbursed by: <input type="checkbox"/> 1- Medicaid <input type="checkbox"/> 2- Private Insurance/HMO <input type="checkbox"/> 3- No Coverage <input type="checkbox"/> 4- Other Public Funding <input type="checkbox"/> 9- Unknown | |
| For Female Patient: | |
| Is This Patient Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Has This Patient Delivered Live-Born Infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

IX. Treatment/Services Referrals (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____ MEDREC# / ID: _____

| | | |
|--|------------------|--|
| For Children of Patient: (Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section) | | |
| Child's Name: | Child's Soundex: | Child's Date of Birth: ____/____/____ |
| Child's Coded ID: | Child's STATENO: | |
| Hospital of Birth: (If Child Was Born at Home, Enter "Home Birth" for Hospital Name) | | |
| Hospital Name: | | Phone Number: () |
| Street Address: | City: | |
| County: | State/Country: | ZIP Code: |

X. *HIV Testing and Antiretroviral Use History (TTH) (Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)

| | | | |
|--|--|---|--|
| Main Source of Testing and Treatment History Information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review | | Date Patient Reported Information: ____/____/____ | |
| <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____ | | | |
| Ever Had a Positive HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown | Date of First Positive HIV Test: ____/____/____ | Ever Had a Negative HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown | Date of Last Negative HIV Test: (If date is from a lab test with test type, enter in Laboratory Data Section.) ____/____/____ |
| Number of Negative HIV Tests Within 24 Months Before First Positive Test (#): _____ <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown | | | |
| Ever Taken Any Antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown | If Yes, What ARV Medications? _____ | | |
| Date ARVs First Taken: ____/____/____ | Date ARVs Last Taken (mm/dd/yyyy): ____/____/____ | | |

XI. Duplicate Review (Office use)

| | | |
|---|-------------------|-----------------|
| Status (check one): <input type="checkbox"/> Same As <input type="checkbox"/> Different Than <input type="checkbox"/> Pending | State Name: _____ | *STATENO: _____ |
|---|-------------------|-----------------|

XII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by: _____ Entered by: _____ Entry Date: _____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

**LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH
600 S. COMMONWEALTH AVE, SUITE 1260
LOS ANGELES, CA 90005**

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