

# ADULT HIV/AIDS CASE REPORT FORM

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

Date Form Received:
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## 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: (    )
	*Social Security Number:	Other ID Type #1:
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"/> Additional 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:	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		
	<i>Outpatient:</i> <input type="checkbox"/> Private Physician <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Other Facility:</i> <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)

<b>After 1977 and before the earliest known diagnosis of HIV infection, this patient had:</b>		
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
<b>HETEROSEXUAL relations with any of the following:</b>	<b>Has the patient:</b>	
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	Perinatally infected (please enter in comments and local/optional fields section): <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	Other documented risk (if yes, specify): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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)

<b>HIV Immunoassays (Non-differentiating)</b>		
<b>TEST 1:</b> <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <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 IA <input type="checkbox"/> HIV-2 WB		
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-Reactive <input type="checkbox"/> Indeterminate		
Manufacturer: _____	<b>Rapid Test</b> (check if rapid): <input type="checkbox"/>	<b>Collection Date:</b> ____/____/____
<b>TEST 2:</b> <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <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 IA <input type="checkbox"/> HIV-2 WB		
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Non-Reactive <input type="checkbox"/> Indeterminate		
Manufacturer: _____	<b>Rapid Test</b> (check if rapid): <input type="checkbox"/>	<b>Collection Date:</b> ____/____/____
<b>HIV Immunoassays (Differentiating)</b>		
<b>TEST:</b> <input type="checkbox"/> HIV-1/2 Ag/Ab Differentiating (Differentiates between HIV Ag and HIV Ab) (e.g. Determined by Alere)		
<b>RESULT:</b> <input type="checkbox"/> HIV Ag <input type="checkbox"/> HIV Ab <input type="checkbox"/> Both (Ag and Ab Reactive) <input type="checkbox"/> Neither (Negative) <input type="checkbox"/> Invalid/Indeterminate		
Manufacturer: _____	<b>Rapid Test</b> (check if rapid): <input type="checkbox"/>	<b>Collection Date:</b> ____/____/____
<b>TEST:</b> <input type="checkbox"/> HIV-1/2 Ag/Ab and Type-Differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab) (e.g. Bio-Rad BioPlex "5th Generation")		
<b>RESULT:</b> COMPLETE THE OVERALL INTERPRETATION AND ANALYTE RESULTS		
<b>Overall Interpretation:</b> <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive Index Value: _____		
<b>Analyte Results:</b>		
<b>HIV-1 Ag:</b> <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Not reportable due to high HIV Ab level Index Value: _____		
<b>HIV-1 Ab:</b> <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive Undifferentiated Index Value: _____		
<b>HIV-2 Ab:</b> <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive Undifferentiated Index Value: _____		
Manufacturer: _____	<b>Collection Date:</b> ____/____/____	
<b>TEST:</b> <input type="checkbox"/> HIV-1/2 Type-Differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab) (e.g. Multispot or Geenius)		
<b>RESULT:</b> <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (Undifferentiated) <input type="checkbox"/> Neither (Negative) <input type="checkbox"/> Indeterminate		
Manufacturer: _____	<b>Rapid Test</b> (check if rapid): <input type="checkbox"/>	<b>Collection Date:</b> ____/____/____



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

STATENO: \_\_\_\_\_ MEDREC# / ID: \_\_\_\_\_

<b>Hospital of Birth:</b> (If Child Was Born at Home, Enter "Home Birth" for Hospital Name)			
Hospital Name:		County:	Phone Number: ( )
Street Address:	City:	State/Country:	ZIP Code:

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

Main Source of Antiretroviral (ARV) Use Information (select one):		Date Patient Reported Information:
<input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____		____/____/____
Ever Taken Any Antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If Yes, Reason for ARV use (select all that apply):		
<input type="checkbox"/> HIV Tx	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____
<input type="checkbox"/> PrEP	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____
<input type="checkbox"/> PEP	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____
<input type="checkbox"/> PMTCT	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____
<input type="checkbox"/> HBV Tx	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____
<input type="checkbox"/> Other:	_____	
	ARV med: _____	Date began: ____/____/____      Date of last use: ____/____/____

**XI. \*HIV Testing History** (Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)

Main Source of Testing History Information (select one):		Date Patient Reported Information:	
<input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____		____/____/____	
Ever Had a Positive HIV Test?	Date of First Positive HIV Test:	Ever Had a Negative HIV Test?	Date of Last Negative HIV Test: (If date is from a lab test with test type, enter in Laboratory Data Section.)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	____/____/____
Number of Negative HIV Tests Within 24 Months Before First Positive Test (#): _____ <input type="checkbox"/> Unknown			

**XII. Duplicate Review (Office use)**

Status (check one): <input type="checkbox"/> Same As <input type="checkbox"/> Different Than <input type="checkbox"/> Pending	State Name:	*STATENO:
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**XIII. Comments and Local/Optional Fields**

<p style="text-align: right;">Assignee: _____ Reviewed by: _____ Entered by: _____ Entry Date: _____</p>
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**PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO**

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH  
600 S. COMMONWEALTH AVE, 10<sup>TH</sup> FLOOR - SUITE 1260  
LOS ANGELES, CA 90005

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**DO NOT SEND THE REPORT BY EMAIL OR FAX.**