Adult HIV Confidential Case Report Form

HIV Counselor Edition

1. PATIENT IDENTIFIER INFORMATION

ID #_____

Patient Name: _____ Phone: ( ) _____-_____

Address:_____ City: _____ County: _____ State: **CT** Zip: _____

Rev 1.16

2. COUNSELOR INFORMATION

Counselor's Name: _____ Phone: ( ) _____-_____

Facility:_____

HEALTH DEPT USE ONLY

HIV test date for TTH	Surv Method	Source	State #	HARMS #	WEEK	YEAR	LN
/ /20____	❑ A ❑ P ❑ F ❑ U					20_____	

3. DEMOGRAPHIC INFORMATION

Diagnostic Status:	Date Of Birth:	Current Status:	Date of Death:	State/Terr Death:
❑ HIV ❑ AIDS	_____/_____/_____	❑ Alive ❑ Dead ❑ Unk	_____/_____/_____	_____

Sex:	Current Gender Identity:	Ethnicity: (Select one)	Race:	Country of Birth:
❑ Male ❑ Female	❑ Male ❑ Female ❑ Trans Male-to-Female ❑ Trans Female-to-Male ❑ Unkn	❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown	❑ Black/AA ❑ White ❑ Asian ❑ AI/Alaskan Native ❑ Hawaiian/PI ❑ Unknown	❑ US ❑ Other_____ ❑ Unknown

Residence of Diagnosis: ❑ **Same as CURRENT ADDRESS**

City:_____ **County**: FFLD HTFD LITCH NH NL MDX TLND WIND **State/Country**: CT/USA **Zip**:

4. FACILITY OF DIAGNOSIS

Facility Name:
City:
State/Country: **CT/USA**
Facility Setting: ❑ Public ❑ Private ❑ Unk
Facility Type: ❑ HIV Testing Site ❑ Other _____

5. PATIENT HISTORY

Before the 1st positive HIV test, this patient had:	Y	N	U
• Sex with male			
• Sex with female			
• Injected drugs			
• Rec'd clotting factor			
Heterosexual relations with the following:			
• IDU			
• Bisexual male			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
Received transfusion or transplant (circle) Date: /			
NO RISK IDENTIFIED			

6. LABORATORY DATA

1. HIV ANTIBODY, TESTS AT DIAGNOSIS:

(Indicate FIRST test)	RESULT		TEST DATE		
	Pos	Neg/Ind	Mo	Day	Yr
HIV-1 EIA					
HIV-1/HIV-2 EIA					
HIV-1 Western Blot					
HIV-1/HIV-2 MULTI SPOT					
SPECIMEN TYPE:		**Oral Fluid**	**X**	**Serum**	

3. DETECTABLE VIRAL LOAD TEST: (Record **MOST RECENT**)

Test Type:	COPIES/ML:	Mo	Day	Yr
RT-PCR				
bDNA				
Other				

DATE OF LAST DOCUMENTED NEGATIVE HIV TEST:

Specify Type:	Mo	Day	Yr
❑ EIA ❑ HIV1/2 ❑ HIV1WB ❑ Other			
If HIV lab tests were not documented, is HIV diagnosis documented by a physician?	Yes	No	Unkn
If **YES**, provide date of MD documentation:	Mo	Day	Yr

4. IMMUNOLOGIC LAB TESTS:

Record CD4 counts <200 or 14%		Mo	Day	Yr
CD4 Count	cells/ul			
CD4 %	%			

Has there been a diagnosis of an AIDS indicator disease? ❑ Y ❑ N

If yes, specify:_____

_____

7. FOR FEMALE PATIENTS

Is this patient currently pregnant? ❑ Yes ❑ No ❑ Unknown	**Has the patient delivered live-born infants?** ❑ Yes ❑ No ❑ Unknown	
Child's date of birth: ___/____/_____	**Hospital of birth:** _____ City: State:	*DPH use only* **State #**:

8. REFERRALS

Has the patient been informed of his/her infection? ❑ Yes ❑ No ❑ Unknown

This patient's partners will be notified about their HIV exposure and counseled by: ❑ Counselor/Provider ❑ Patient ❑ Unknown

Health Care Providers can request assistance for notification of potentially exposed partners. Would you like this assistance from DPH? ❑ Yes, please! ❑ No, thanks!

Where has the patient been referred for HIV care? **MD/Facility:** _____

9. COMMENTS:

10. HIV TESTING & TREATMENT HISTORY

Source of TTH information: ❑ **Patient Interview** ❑ **Chart abstraction** ❑ **CareWare** ❑ **xPEMS** ❑ **Other**

1. Date patient answered the questions: _____/_____/_____ (mo/day/year)
2. Has the patient ever had a **previous positive** HIV test? ❑ Yes ❑ No ❑ Unknown
3. When was the **first** time the patient ever tested **positive** for HIV? _____/_____ (mo/yr)
4. What was the date of the patient's **last negative** HIV test? _____/_____ (mo/yr)
5. How many times did the patient get tested for HIV in the 2 years before the first positive HIV test? _____ times
6. Why was the patient tested for HIV? ❑ Routine test ❑ Rule out HIV ❑ Symptoms/Dx w/ OI ❑ Partner dx w/ HIV ❑ 'Just checking' ❑ Regular tester ❑ Other: _____
7. Did the patient ever use antiretroviral medicine?

❑ Yes **(Go to question 7a)** ❑ No **(STOP! You are finished!)** ❑ Don't know **(STOP! You are finished!)**

7a. Why did the patient use antiretroviral medicine?

ARV use type	ARV Medication(s)	Date began	Date of last use
❑ HIV Tx			
❑ PrEP			
❑ PEP			
❑ PMTCT			
❑ HBV Tx			
❑ Other			

(HIV Tx – HIV treatment; PrEP - PRE-exposure prophylaxis; PEP - POST-exposure prophylaxis; PMTCT - prevention of mother-to-child transmission; HBV Tx – Hepatitis B treatment)