Delaware Adult HIV Confidential Case Report Form

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

Date Entered: _____/_____/_____

I. HEALTH DEPARTMENT USE ONLY

Document ID	Soundex Code	Report Status	Date Rec'd at DPH	State Number
DE00-		New Update	_____/_____/_____	
Document Source	**New Investigation**	**Report Medium**	**Surveillance Method**	
	Y N U		A F P R U	

II. PATIENT IDENTIFIER INFORMATION – *data not transmitted to CDC*

Name: (Last First Middle) | Alias: | SSN:

Current Address:

City: | County: | State: | Zip: | Phone:

III. FORM INFORMATION

Date form completed: _____/_____/_____ | Person completing form: | Phone:

IV. CURRENT PROVIDER INFORMATION

Physician: | Facility:

City: | State: | Phone:

V. DEMOGRPAHIC INFORMATION – *complete ALL fields*

Diagnostic Status:	Sex at Birth:	Date of Birth:	Country of Birth:		Vital Status:
☐ Adult HIV ☐ Adult AIDS	☐ Male ☐ Female	___/___/_____	☐ U.S. ☐ Unknown	☐ U.S. Territory ☐ Other	☐ Alive ☐ Dead ☐ Unknown Death Date: ___/___/_____ State/Terr of Death:

Marital Status: S M W D Oth Unk

Race (check all that apply):
☐ Black/AA ☐ White ☐ Asian ☐ Native American/Alaskan
☐ Hawaiian/PI ☐ Unk ☐ Other _____

Ethnicity: Hispanic ☐ Y ☐ N ☐ Unk

Residence at HIV Diagnosis: ☐ Same as Current
City: | County: | Street Address: | State/Country: | Zip:

Residence at AIDS Diagnosis: ☐ Same as Current
City: | County: | Street Address: | State/Country: | Zip:

VI. FACILITY OF DIAGNOSIS

HIV Facility:
Address:
City, State/Country:
Phone:

AIDS Facility:
Address:
City, State/Country:
Phone:

HIV	Facility Type	AIDS
	Private Physician	
	Hospital Inpatient	
	Outpatient	
	Emergency Department	
	Other: _____	

VII. PATIENT HISTORY – *complete ALL fields*

BEFORE THE 1ST POSITIVE HIV TEST, PATIENT HAD:	Y	N	U
Sex with male			
Sex with female			
Injected Drugs			
Received clotting factor			
Heterosexual relations with the following:			
• Injecting Drug User (IDU)			
• Bisexual male (**applies to females only**)			
• Person with hemophilia/coagulation disorder			
• Transfusion recipient w/documented HIV infection			
• Personal with AIDS or documented HIV infection, **risk unspecified**			
Received transfusion: Date 1st: ___/_____ Date last: ___/_____			
Received organ transplant, tissue or artificial insemination			
Worked in healthcare/clinical laboratory **OCCUPATION:**			
Perinatally Infected			
Other: _____			

VIII. DUPLICATE REVIEW

IX. COMMENTS

X. DOCUMENTED LABORATORY DATA

For the LCTN (LOCATION) columns please indicate the State or Out of Country residence of the patient at the time of that lab

HIV DIAGNOSTIC TESTS: (First known positive test and pre-diagnostic negative test)

LCTN	Test Type	RESULT: Rapid	Pos	Ag+	Neg	Indet	TEST DATE: M	D	Y
	HIV-1/2 Ag/Ab **Lab** IA (4th Gen *P24-Distinguishing*)								
	HIV-1/2 Ag/Ab **Rapid** IA (4th Gen *P24-Distinguishing*) **(Alere Determine)**								
	HIV-1/2 Ag/Ab **Lab** IA 4th Gen								
	HIV-1/2 Ag/Ab **Lab** IA (4th Gen *P24-Distinguishing and Type Differentiating*) **(Bio-Plex 2200)** HIV-1 ☐ HIV-2 ☐ Both ☐								
	HIV-1/2 Ab IA (2nd/3rd Gen)								
	HIV-1/2 (*Type Differentiating*) **(Multispot or Geenius)** HIV-1 ☐ HIV-2 ☐ Both ☐								
	HIV-1 EIA or Other								
	HIV-2 EIA or Other								
	HIV1 Western Blot								
	HIV-1 RNA/DNA **QUAL** NAAT								
	Last Pre-DX Negative Test Test Type:								

VIRAL LOAD TESTS: (EARLIEST AND MOST RECENT tests)

Detectable	Undetectable	Copies/ML	TEST DATE: M	D	Y	LCTN
☐	☐					
☐	☐					

IMMUNOLOGIC LAB TESTS:

At or closest to current diagnostic status	M	D	Y	LCTN
CD4 Count: _____ cells/ul (_____%)				
CD4 Count: _____ cells/ul (_____%)				

First Stage 3 HIV lymphocyte <200 cells/µL or a CD4+ <14%

CD4 Count: _____ cells/ul (_____%)				
CD4 Count: _____ cells/ul (_____%)				

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not documented, is HIV diagnosis documented by a physician? Yes ☐ No ☐ Unk ☐

If YES, provide date of physician documentation	M	D	Y	LCTN

DOCUMENTATION OF TESTS

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? Yes ☐ No ☐ Unknown ☐

If YES, provide specimen collection date of earliest positive test for this algorithm ___ /___ /_____

Complete the above only if none of the following was positive: HIV 1 Western Blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA)

XI. STAGE 3 HIV INDICATOR DISEASES

Disease:	DX Date
Candidiasis, bronchi, trachea, or lungs	__/__/____
Candidiasis, esophageal	__/__/____
Cervical cancer, invasive	__/__/____
Coccidioidomycosis, disseminated or extrapulmonary	__/__/____
Cryptococcosis, extrapulmonary	__/__/____
Cryptosporidiosis, chronic intestinal	__/__/____
Cytomegalovirus disease (other than liver, spleen, or nodes)	__/__/____
Cytomegalovirus retinitis (with loss of vision)	__/__/____
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	__/__/____
HIV encephalopathy	__/__/____
Histoplasmosis, diss. or extrapulmonary	__/__/____
Isosporiasis, chronic intestinal	__/__/____
Kaposi's sarcoma	__/__/____
Lymphoma, Burkitt's (or equivalent)	__/__/____
Lymphoma, immunoblastic (or equivalent)	__/__/____
Lymphoma, primary in brain	__/__/____
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	__/__/____
M. tuberculosis, pulmonary	__/__/____
M. tuberculosis, diss. or extrapulmonary	__/__/____
Mycobacterium of other or unidentified species, diss. or extrapulmonary	__/__/____
Pneumocystis carinii pneumonia	__/__/____
Pneumonia, recurrent	__/__/____
Progressive multifocal leukoencephalopathy	__/__/____
Salmonella septicemia, recurrent	__/__/____
Toxoplasmosis of brain	__/__/____
Wasting syndrome due to HIV	__/__/____

XII. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? Yes ☐ No ☐ Unknown ☐

This patient's partners will be notified about their HIV exposure and counseled by:

☐ Local Health Dept
☐ Physician/provider

This patient's medical treatment is primarily reimbursed by:

HIV ☐ AIDS ☐	Medicaid/Medicare
HIV ☐ AIDS ☐	Private insurance
HIV ☐ AIDS ☐	No coverage
HIV ☐ AIDS ☐	Other public funding
HIV ☐ AIDS ☐	Clinic trial/program
HIV ☐ AIDS ☐	Unknown

	Yes	No	Unk
Is patient enrolled in a clinic/clinical trial? If YES, name: _____	☐	☐	☐
Is patient receiving or been referred for:			
• HIV related medical services?	☐	☐	☐
• Substance Abuse treatment services?	☐	☐	☐
• Anti-retroviral Therapy	☐	☐	☐
• PCP prophylaxis	☐	☐	☐

XIII. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services? If YES, physician: _____	☐	☐	☐
Is patient currently pregnant? If YES, EDC (due date): ___ /___ /_____	☐	☐	☐
Has patient delivered a live-born infant?	☐	☐	☐

If YES, provide Grava _____ Para _____ and information below for most RECENT birth

Child's Name: _____

Date of Birth: ___ /___ /_____

Sex at Birth: ☐ Male ☐ Female

Country of Birth: _____

Hospital of Birth: _____

Hospital Address: _____

XIV. ADDITIONAL COMMENTS: