Completing the new Adult/Adolescent HIV and AIDS Confidential Case Report Form

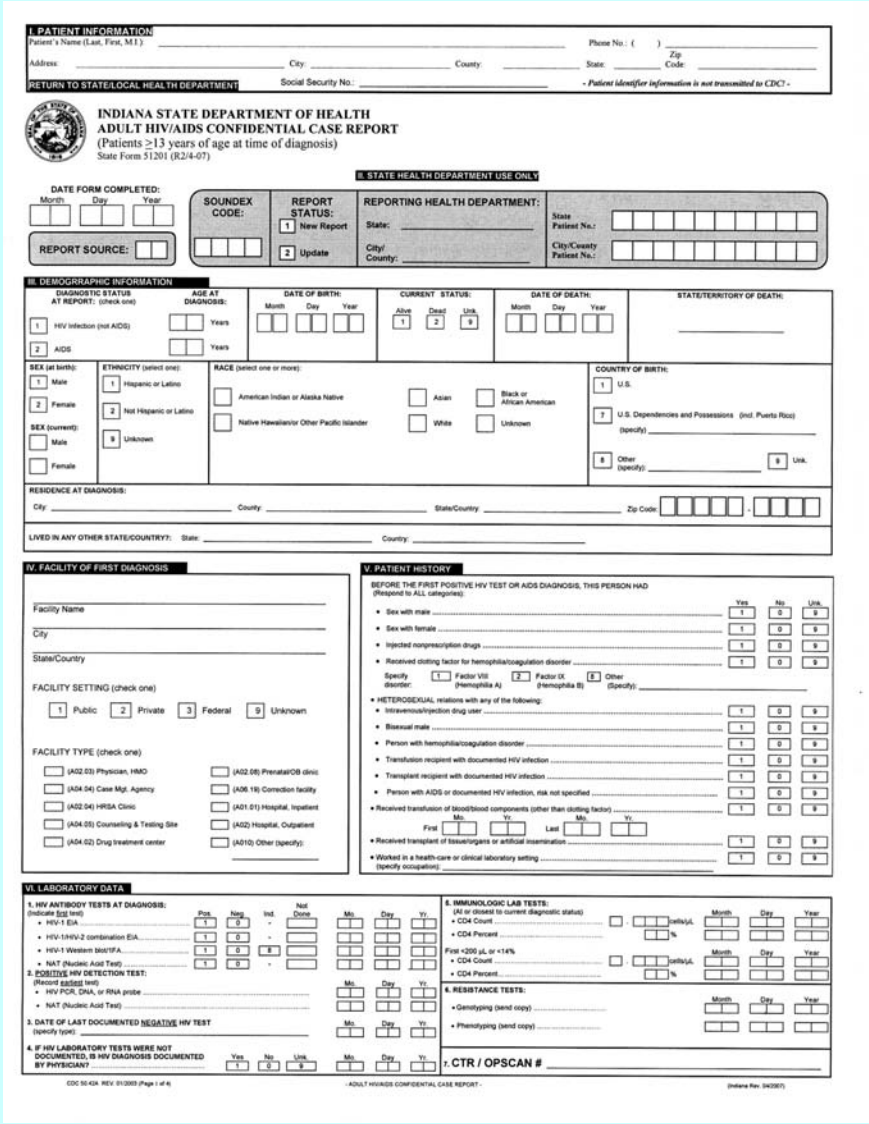
Office of Clinical Data and Research
Indiana State Department of Health
Toll free 800-376-2501 or 317-233-7406

HIV/AIDS Case Report Forms

Accurate, thorough, case reports provide demographic information regarding the spread of the HIV/AIDS infection.

Reporting sex, race, ethnicity, and behavior allows us to to gear programs toward specific populations and areas of need.

Case reports need to be initiated within 72 hours after notifying the person they are positive. If a person does not return for their test result, send in the report at that time. All HIV-infected pregnant women must be reported immediately. All babies born to HIV-infected or AIDS-diagnosed mothers must be reported immediately after birth. Please indicate the baby's pediatrician.



I. PATIENT INFORMATION

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

Address: City: County: State: Zip Code:

RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security No.: - Patient identifier information is not transmitted to CDC? -

INDIANA STATE DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥13 years of age at time of diagnosis)
State Form 51201 (R2/4-07)

II. STATE HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED: Month Day Year

REPORT SOURCE:

SOUNDEX CODE:

REPORT STATUS: 1 New Report 2 Update

REPORTING HEALTH DEPARTMENT: 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: Month Day Year

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Month Day Year

STATE/TERRITORY OF DEATH:

SEX (at birth): 1 Male 2 Female

SEX (current): Male Female

ETHNICITY (select one): 1 Hispanic or Latino 2 Not Hispanic or Latino 9 Unknown

RACE (select one or more): American Indian or Alaska Native Asian Black or African American Native Hawaiian/or Other Pacific Islander White Unknown

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) 8 Other (specify): 9 Unk.

RESIDENCE AT DIAGNOSIS: City: County: State/Country: Zip Code:

LIVED IN ANY OTHER STATE/COUNTRY?: State: Country:

IV. FACILITY OF FIRST DIAGNOSIS

Facility Name

City

State/Country

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unknown

FACILITY TYPE (check one)

(A02.03) Physician, HMO
(A04.04) Case Mgt. Agency
(A02.04) HRSA Clinic
(A04.05) Counseling & Testing Site
(A04.02) Drug treatment center
(A02.08) Prenatal/OB clinic
(A06.19) Correction facility
(A01.01) Hospital, Inpatient
(A02) Hospital, Outpatient
(A010) Other (specify):

V. PATIENT HISTORY

BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON 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:
  - 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) Mo. Yr. First Mo. Yr. Last 1 0 9
- Received transplant of tissue/organs or artificial insemination 1 0 9
- Worked in a health-care or clinical laboratory setting (specify occupation): 1 0 9

VI. LABORATORY DATA

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

	Pos.	Neg.	Ind.	Not Done	Mo.	Day	Yr.
• HIV-1 EIA	1	0	-				
• HIV-1/HIV-2 combination EIA	1	0	-				
• HIV-1 Western blot/IFA	1	0	8				
• NAT (Nucleic Acid Test)	1	0	-				

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

	Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe			
• NAT (Nucleic Acid Test)			

3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (specify type): Mo. Day Yr.

4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes 1 No 0 Unk. 9 Mo. Day Yr.

5. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

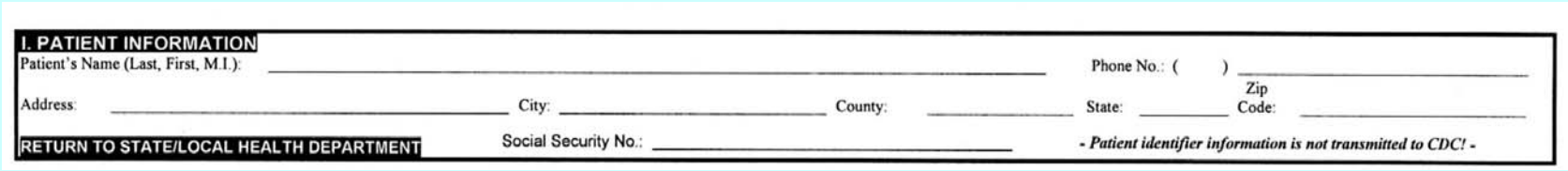
		Month	Day	Year
• CD4 Count	cells/µL			
• CD4 Percent	%			
First <200 µL or <14%				
• CD4 Count	cells/µL			
• CD4 Percent	%			

6. RESISTANCE TESTS:

	Month	Day	Year
• Genotyping (send copy)			
• Phenotyping (send copy)			

7. CTR / OPSCAN #

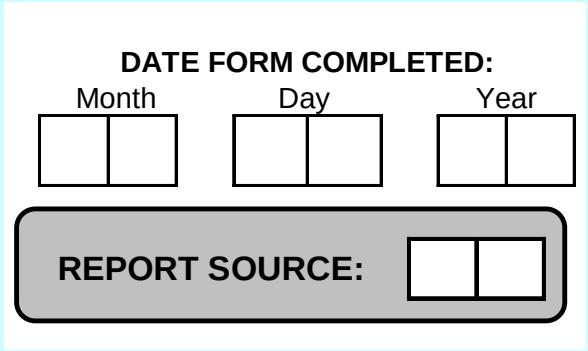
CDC 50.42A REV. 01/2003 (Page 1 of 4) - ADULT HIV/AIDS CONFIDENTIAL CASE REPORT - (Indiana Rev. 04/2007)


I. PATIENT INFORMATION
Patient's Name (Last, First, M.I.): _____ Phone No.: ( ) _____
Address: _____ City: _____ County: _____ State: _____ Zip Code: _____
RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security No.: _____ - Patient identifier information is not transmitted to CDC! -

- **Print the legal name. If known, put maiden names and aliases in parentheses.**

- **For Dept of Correction inmates, include both the name <u>and</u> offender number. It is NOT enough to list just the offender number.**

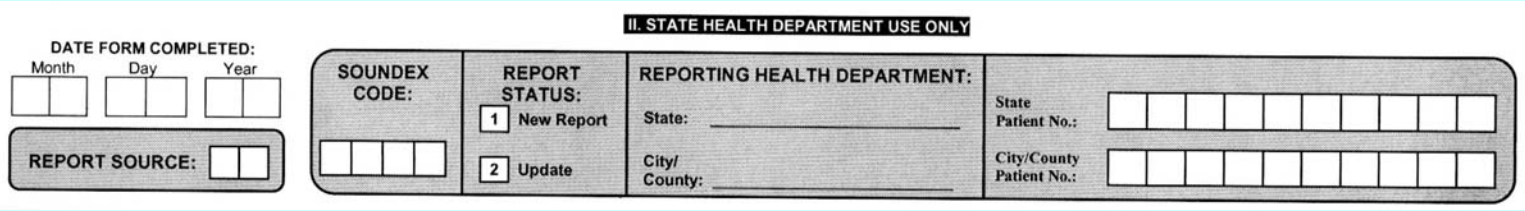
- **Enter the social security number. It is used to make certain we have the correct person and to prevent duplication of patients.**

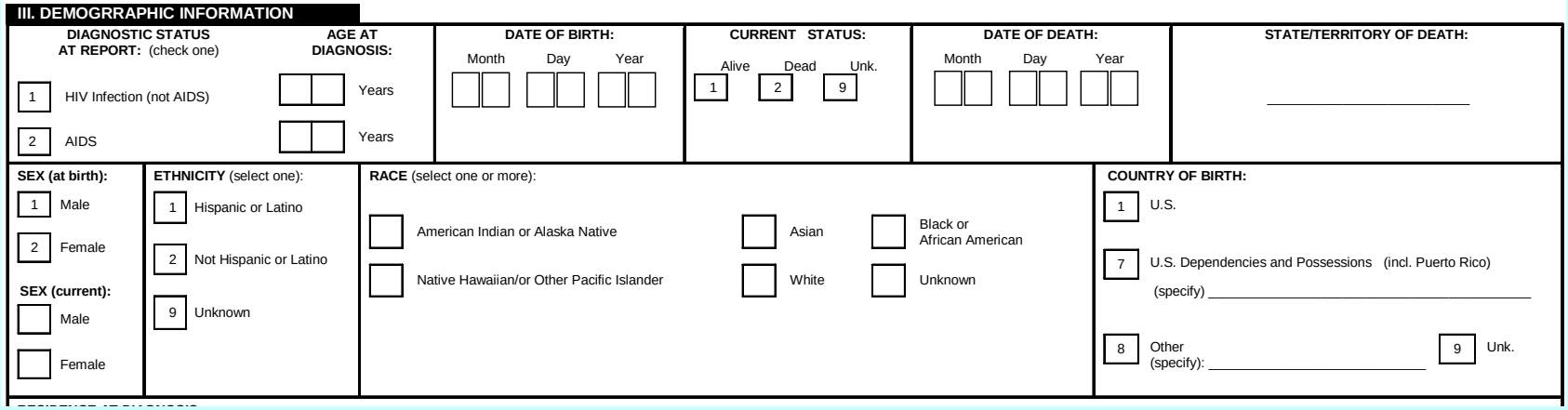


- **Enter the date the report is completed.**

- **ISDH will complete the report source.**

II. STATE HEALTH DEPARTMENT USE ONLY





III. DEMOGRRAPHIC INFORMATION

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

AGE AT DIAGNOSIS:
Years
Years

DATE OF BIRTH: Month Day Year

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Month Day Year

STATE/TERRITORY OF DEATH:

SEX (at birth):
1 Male
2 Female

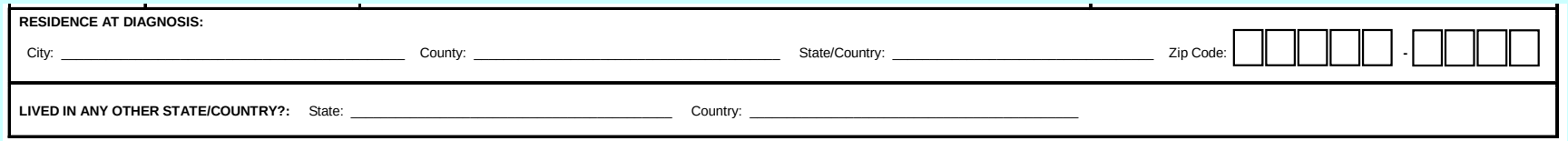
SEX (current):
Male
Female

ETHNICITY (select one):
1 Hispanic or Latino
2 Not Hispanic or Latino
9 Unknown

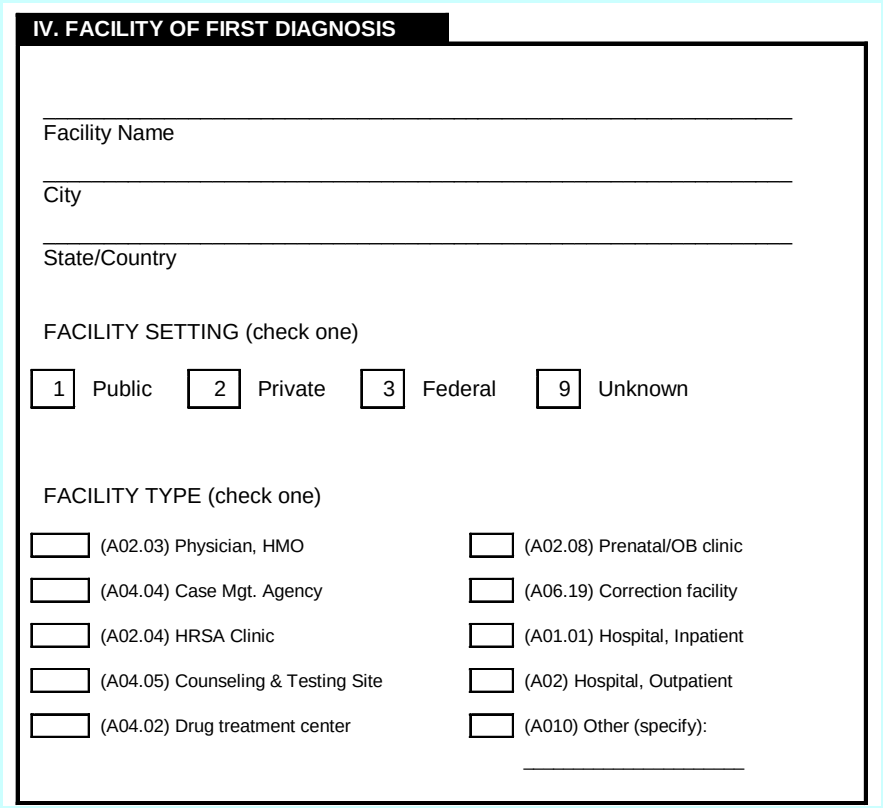
RACE (select one or more):
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian/or Other Pacific Islander
White
Unknown

COUNTRY OF BIRTH:
1 U.S.
7 U.S. Dependencies and Possessions (incl. Puerto Rico)
(specify) _____
8 Other (specify): _____
9 Unk.

- **Indicate whether the person is infected with HIV or has progressed to an AIDS diagnosis.**
- **Enter the date of birth correctly and legibly.**
- **Indicate if the person is alive or deceased. If deceased, enter the date of death and the state/territory where the person died.**
- **Mark the sex at birth and the current sex.**
- **Indicate both the ethnicity and the race(s) of the person.**
- **Complete the Country of Birth. If born outside of the United States, write in the country.**



- **Enter the residence at first diagnosis. <u>It may not be the patient's current address</u> – include the county, state/country if outside United States and zip code.**
- **Indicate any other states/countries where person may have lived. Enter this information even if it was prior to their diagnosis.**



IV. FACILITY OF FIRST DIAGNOSIS

_____
Facility Name

_____
City

_____
State/Country

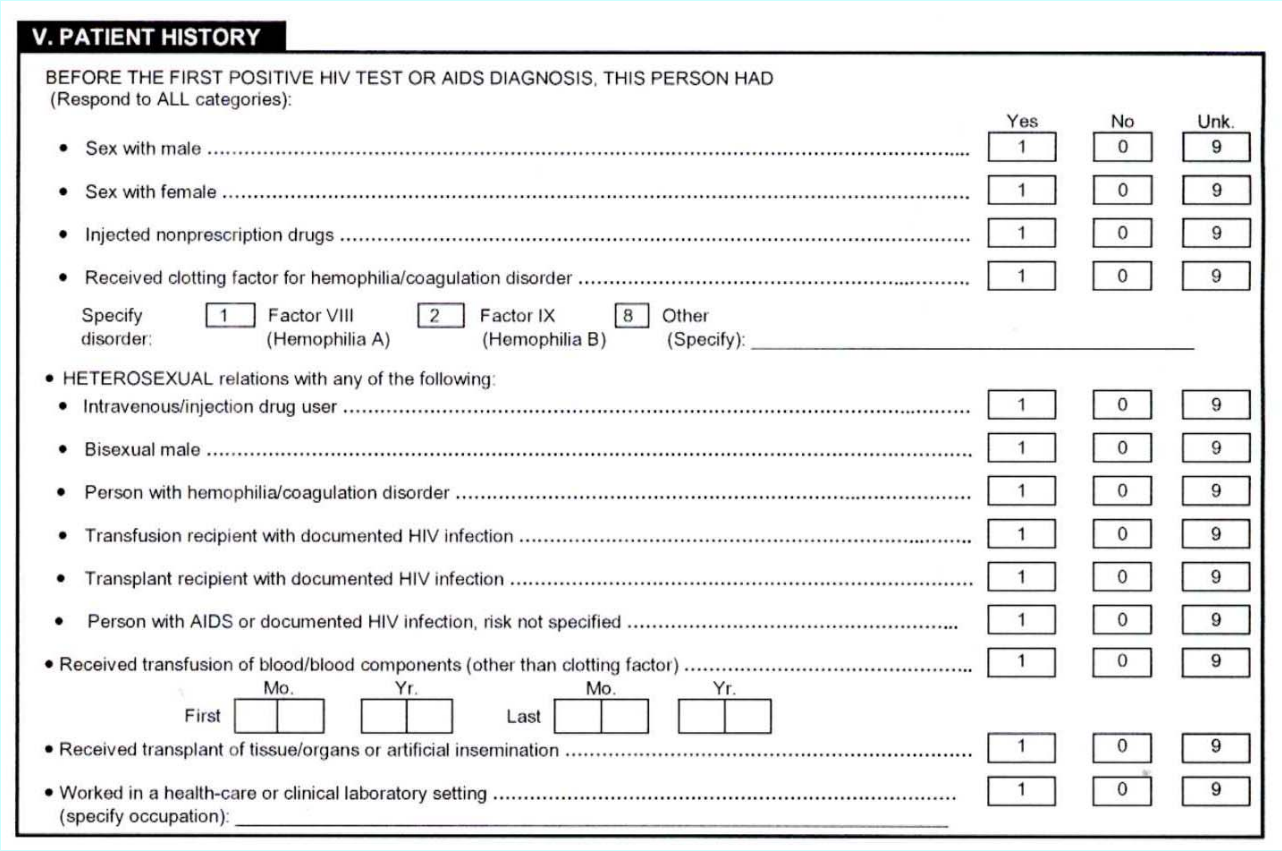
FACILITY SETTING (check one)

[ ] 1 Public [ ] 2 Private [ ] 3 Federal [ ] 9 Unknown

FACILITY TYPE (check one)

[ ] (A02.03) Physician, HMO
[ ] (A04.04) Case Mgt. Agency
[ ] (A02.04) HRSA Clinic
[ ] (A04.05) Counseling & Testing Site
[ ] (A04.02) Drug treatment center
[ ] (A02.08) Prenatal/OB clinic
[ ] (A06.19) Correction facility
[ ] (A01.01) Hospital, Inpatient
[ ] (A02) Hospital, Outpatient
[ ] (A010) Other (specify):
_____

- **Enter the entire name of the facility where the first positive HIV test was collected. Include the city and state/country of the facility.**
- **The facility of <u>first</u> diagnosis may be different from the facility where the form is being completed.**
- **Indicate if the facility is public, private, federal, or you do not know.**
- **Indicate the facility type.**



V. PATIENT HISTORY

BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON 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:			
• 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.

• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting (specify occupation): _____	1	0	9

- **Patient History is important in determining a person's probable source of exposure to HIV.**
- **Indicate <u>yes, no, or unknown</u> for all bullet points. Ask the person, do not guess.**

- **Indicate the type of test used for diagnosis; the result; and the month, day, and year of the test. There must be a positive Western Blot (WB) or physician's diagnosis for an HIV diagnosis.**

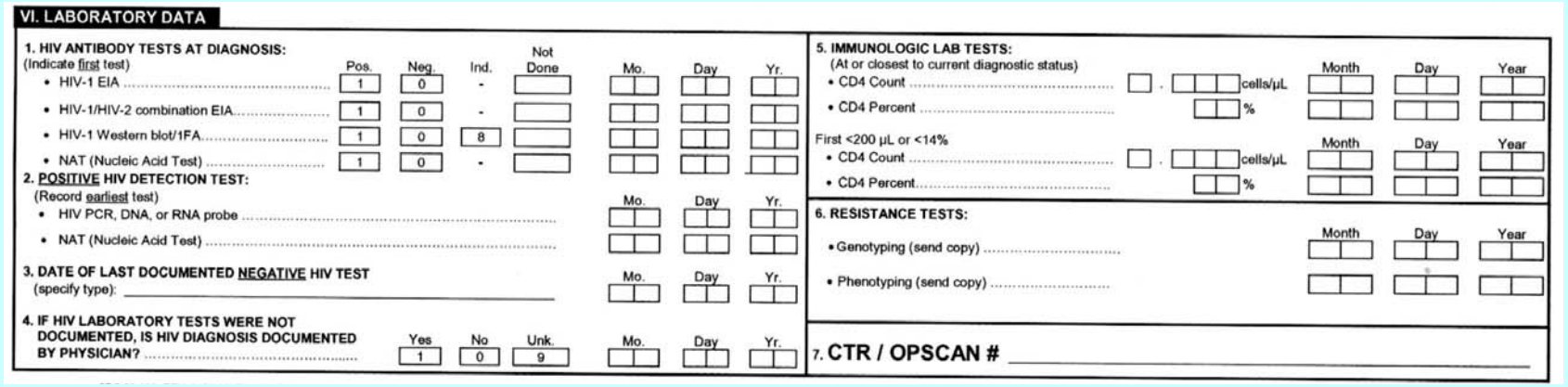
- **If there is only a positive EIA/ELISA with a negative or indeterminate WB and NO physician's diagnosis, DO NOT complete a case report form. For a negative WB, depending on risky behavior, offer an appropriate retesting timeframe. A WB that is indeterminate should be repeated.**

- **Indicate the date of the last negative HIV test.**

- **If a physician wants to document an HIV diagnosis without test results to back the diagnosis, he/she must indicate the month, day, and year that the diagnosis was determined. Indicate in the comment section why the diagnosis is being made.**

- **Indicate CD4 results and genotype/phenotype information in the appropriate boxes.**

- **Counseling and Testing Sites: You must indicate the CTR/OPSCAN Number on line #7.**



VI. LABORATORY DATA

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

	Pos.	Neg.	Ind.	Not Done	Mo.	Day	Yr.
• HIV-1 EIA	1	0	-				
• HIV-1/HIV-2 combination EIA	1	0	-				
• HIV-1 Western blot/1FA	1	0	8				
• NAT (Nucleic Acid Test)	1	0	-				

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

	Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe			
• NAT (Nucleic Acid Test)			

3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (specify type): _____ Mo. Day Yr.

4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes 1 | No 0 | Unk. 9 — Mo. Day Yr.

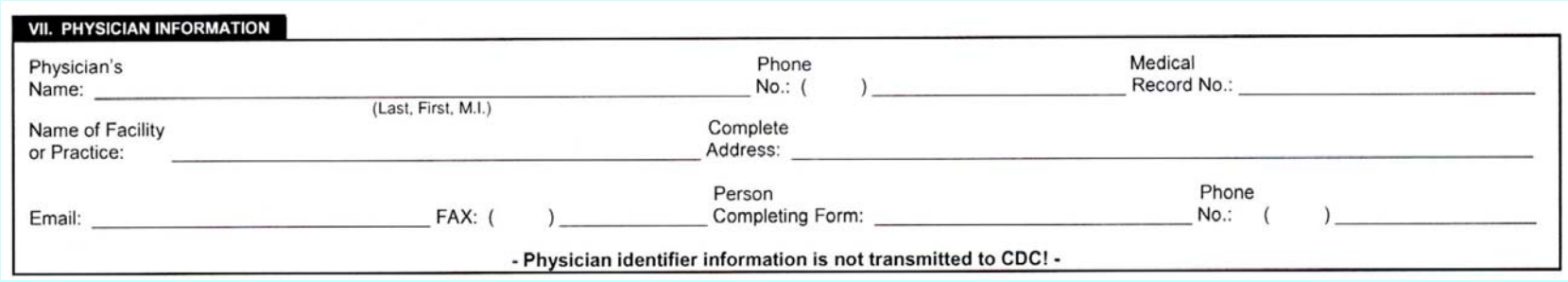
5. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

		Month	Day	Year
• CD4 Count	. cells/µL			
• CD4 Percent	%			
First <200 µL or <14%				
• CD4 Count	. cells/µL			
• CD4 Percent	%			

6. RESISTANCE TESTS:

	Month	Day	Year
• Genotyping (send copy)			
• Phenotyping (send copy)			

7. CTR / OPSCAN # _____



VII. PHYSICIAN INFORMATION

Physician's Name: _____ (Last, First, M.I.)

Phone No.: ( ) _____

Medical Record No.: _____

Name of Facility or Practice: _____

Complete Address: _____

Email: _____

FAX: ( ) _____

Person Completing Form: _____

Phone No.: ( ) _____

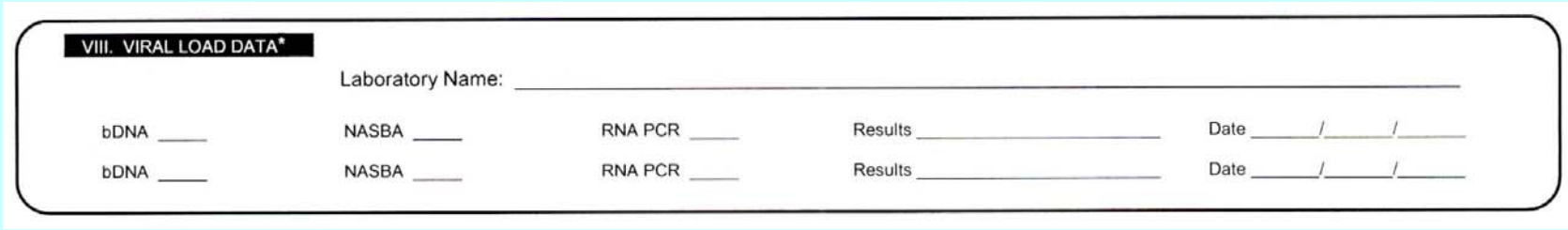
- Physician identifier information is not transmitted to CDC! -

- **Legibly print the physician's first name and last name and the phone number where the physician can be reached.**

- **Please include the medical record number, if available.**

- **Indicate the Hospital/Facility where the patient/client is receiving care at the time the form is completed. Indicate the email address and fax number of the facility.**

- **Indicate legibly the first name and last name of the person completing this form and the phone number where they can be reached.**


VIII. VIRAL LOAD DATA*

Laboratory Name: _____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date ____/____/____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date ____/____/____

- **Indicate the laboratory that ran the viral load test. Mark the type of test run, the result, and the date the blood was drawn/collected.**

- **Information listed here will define an AIDS diagnosis.**
- **Be sure of the diagnosis and the date of diagnosis. Be certain there is a definitive diagnosis for those that do not allow a presumptive diagnosis.**

IX. 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 ___ Day ___ Yr. ___ Symptomatic (not AIDS): Mo ___ Day ___ Yr. ___

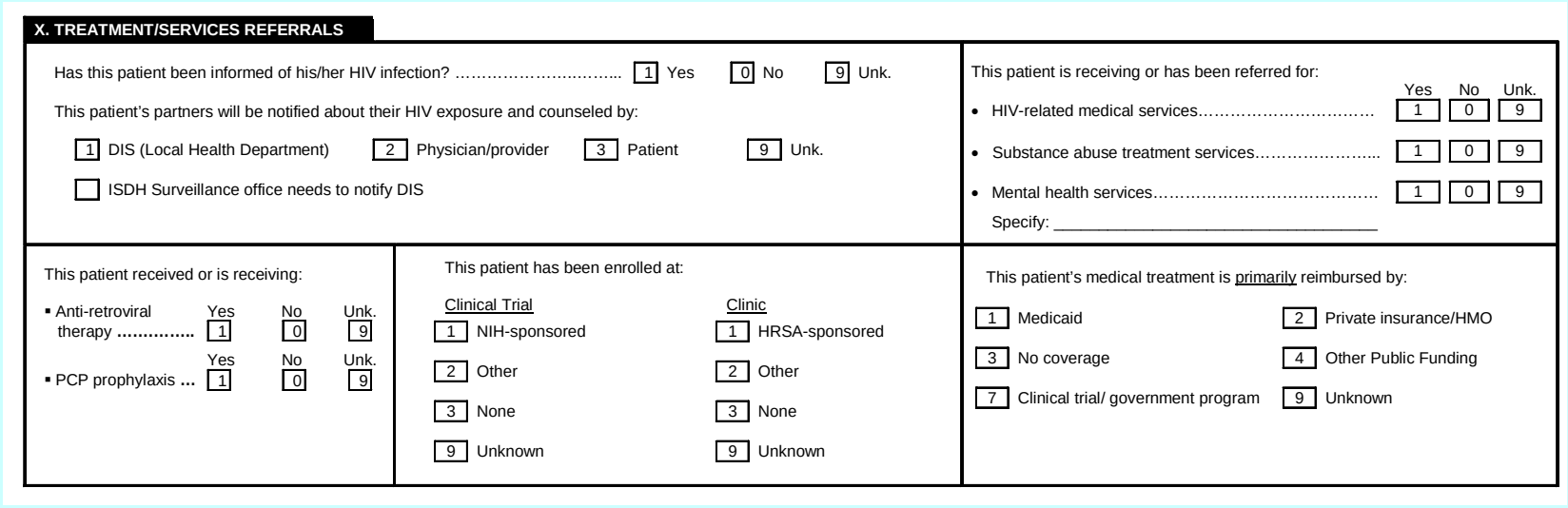
AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Day	Yr.
1) Candidiasis, bronchi, trachea, or lungs	1	NA			
2) Candidiasis, esophageal	1	2			
3) Carcinoma, invasive cervical	1	NA			
4) Coccidioidomycosis, disseminated or .extrapulmonary	1	NA			
5) Cryptococcosis, extrapulmonary	1	NA			
6) Cryptosporidiosis, chronic intestinal (>1 Mo. duration)	1	NA			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			
8) Cytomegalovirus retinitis (with loss of vision)	1	2			
9) HIV encephalopathy	1	NA			
10) Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			
11) Histoplasmosis, disseminated or extra pulmonary	1	NA			
12) Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			
13) Kaposi's sarcoma	1	2			

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Day	Yr.
14) Lymphoma, Burkitt's (or equivalent term)	1	NA			
15) Lymphoma, immunoblastic (or equivalent term)	1	NA			
16) Lymphoma, primary in brain	1	NA			
17) *Mycobacterium avium* complex or M. Kansasii, disseminated or extrapulmonary	1	2			
18) *M. tuberculosis, pulmonary**	1	2			
19) *M. tuberculosis*, disseminated or extrapulmonary*	1	2			
20) *Mycobacterium*, of other species or unidentified species,disseminated or extrapulmonary	1	2			
21) *Pneumocystis carinii* pneumonia	1	2			
22) *Pneumonia*, recurrent, in 12 mo. period	1	2			
23) Progressive multifocal leukoencephalopathy	1	NA			
24) Salmonella septicemia, recurrent	1	NA			
25) Toxoplasmosis of brain	1	2			
26) 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



X. 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] DIS (Local Health Department) [2] Physician/provider [3] Patient [9] Unk.

[ ] ISDH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

	Yes	No	Unk.
• HIV-related medical services……	1	0	9
• Substance abuse treatment services……	1	0	9
• Mental health services……	1	0	9

Specify: _____

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:

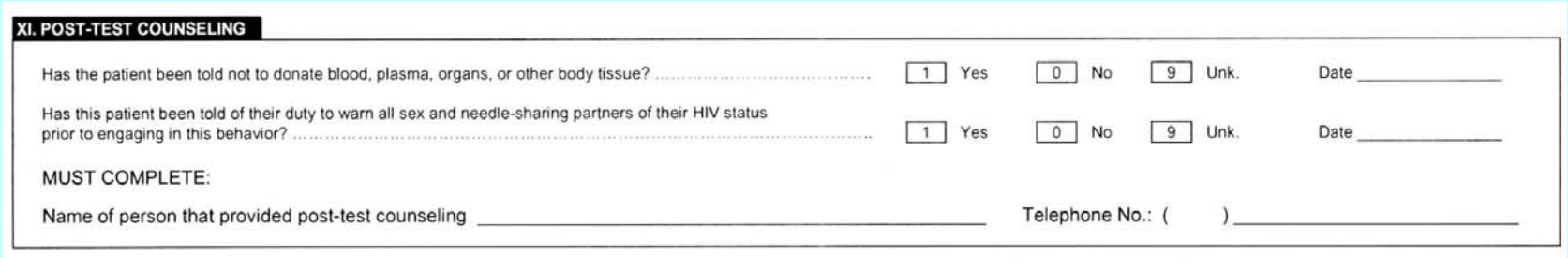
Clinical Trial	Clinic
1 NIH-sponsored	1 HRSA-sponsored
2 Other	2 Other
3 None	3 None
9 Unknown	9 Unknown

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

- **Indicate if the person has been informed of his/her diagnosis.**
- **Indicate who will notify partners.**
- **Specify Mental Health Service referrals. Indicate for what purpose: specify bipolar, schizophrenia, paranoia, depression, non-injection drug use, alcohol abuse, suicidal tendencies, etc.**
- **Complete all sections regarding treatment accurately and completely.**

- **The person providing the positive test result MUST post-test counsel the patient. This MUST include informing him/her that there are laws that say they may not donate blood, plasma, organs or tissue, AND that they MUST inform all sex and needle sharing partners BEFORE they engage in any sexual or needle sharing acts. However, it is important that ALL subsequent health care providers reinforce this point and document it in their medical records.**
- **Indicate the first and last name of the person who did the post-test counseling and the phone number where they can be reached.**



XI. POST-TEST COUNSELING

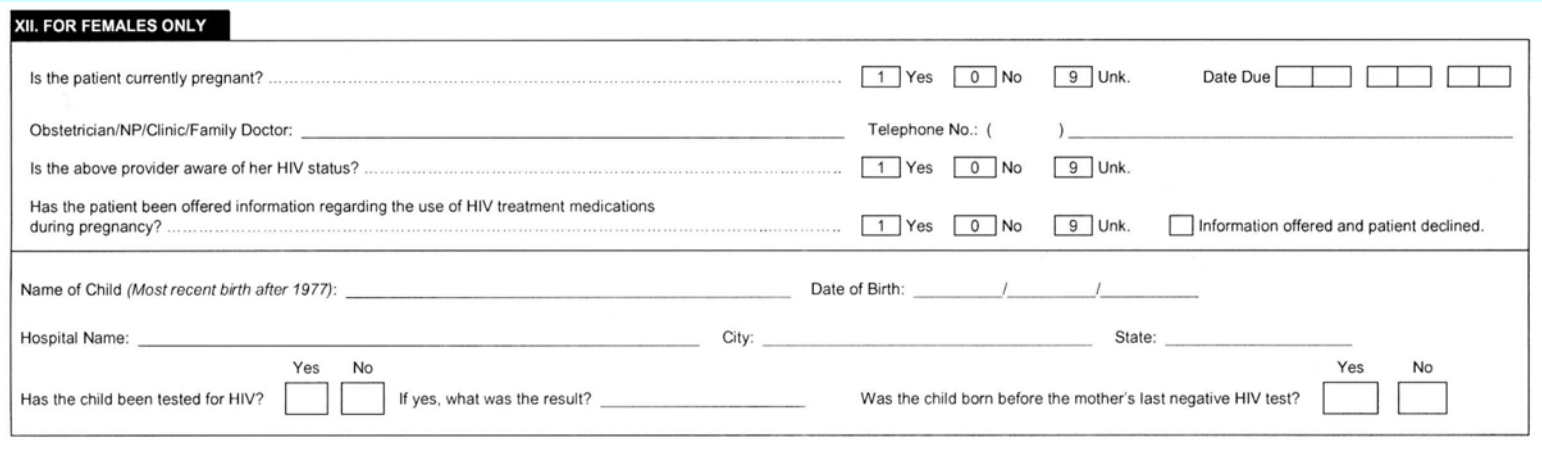
Has the patient been told not to donate blood, plasma, organs, or other body tissue? ..... [1] Yes [0] No [9] Unk. Date _____

Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior? ..... [1] Yes [0] No [9] Unk. Date _____

MUST COMPLETE:

Name of person that provided post-test counseling _____ Telephone No.: ( ) _____

COMPLETE THIS SECTION FOR ALL FEMALES



XII. FOR FEMALES ONLY

Is the patient currently pregnant? ..... 1 Yes 0 No 9 Unk. Date Due ☐☐ ☐☐ ☐☐

Obstetrician/NP/Clinic/Family Doctor: _____ Telephone No.: ( ) _____

Is the above provider aware of her HIV status? ..... 1 Yes 0 No 9 Unk.

Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ..... 1 Yes 0 No 9 Unk. ☐ Information offered and patient declined.

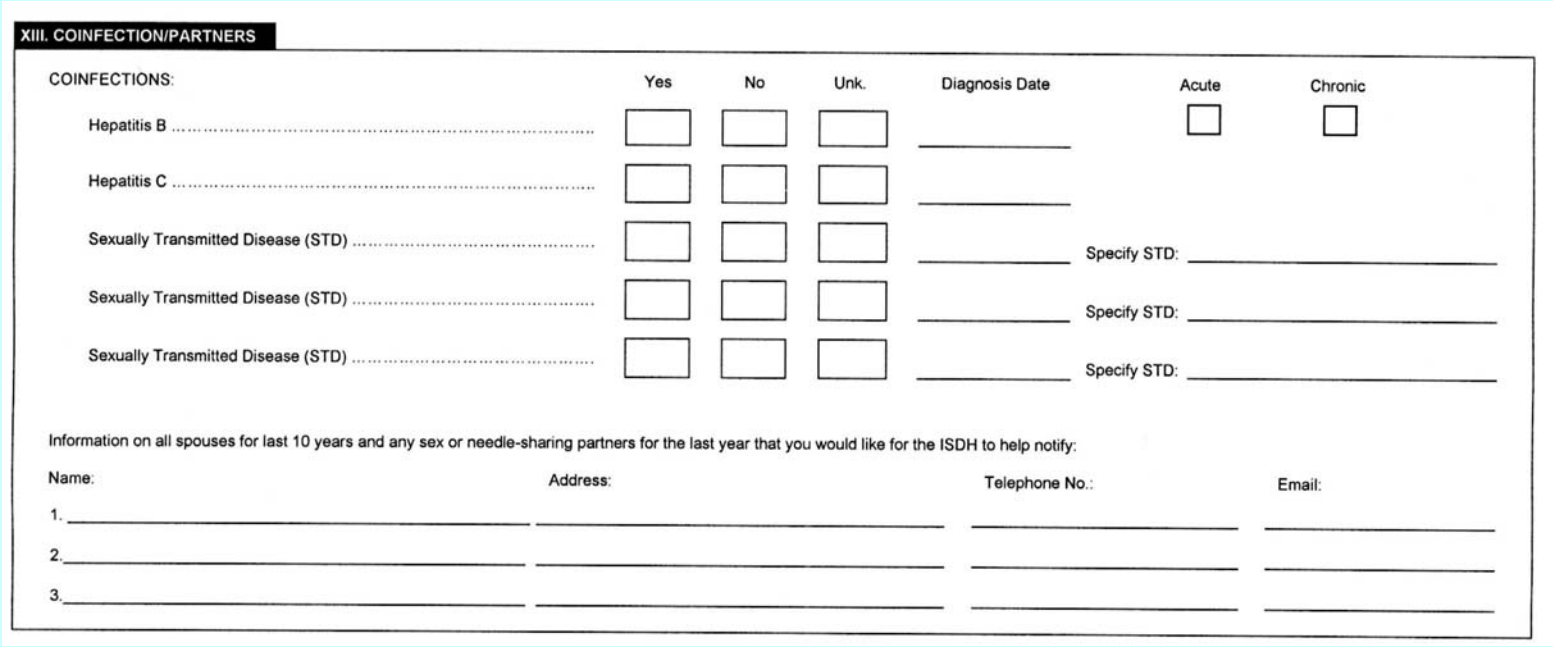
Name of Child *(Most recent birth after 1977)*: _____ Date of Birth: ____/____/____

Hospital Name: _____ City: _____ State: _____

Has the child been tested for HIV? Yes ☐ No ☐ If yes, what was the result? _____

Was the child born before the mother's last negative HIV test? Yes ☐ No ☐

- **Indicate if the patient is currently pregnant.**
- **Enter the date of expected delivery.**
- **Indicate the name and phone number of the health care provider for this pregnancy.**
- **Indicate if the health care provider is or is not aware of the patient's HIV status.**
- **Indicate if the patient has received information on antiretroviral medications in relationship to pregnancy. Indicate if she declined medications.**
- **List the name of the most recent birth since 1977 and his/her birth date.**
- **Indicate the name of the hospital, city, and state where the child was born. Has the child been tested? List the result. Indicate if this child was born before the mother's last negative test.**



XIII. COINFECTION/PARTNERS

COINFECTIONS:	Yes	No	Unk.	Diagnosis Date	Acute	Chronic
Hepatitis B	☐	☐	☐	_____	☐	☐
Hepatitis C	☐	☐	☐	_____		
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____	
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____	
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____	

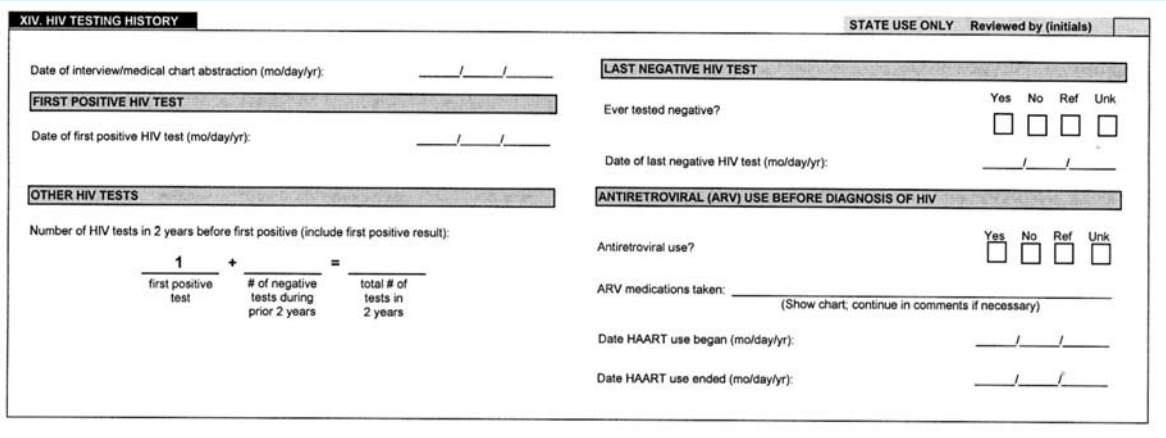
Information on all spouses for last 10 years and any sex or needle-sharing partners for the last year that you would like for the ISDH to help notify:

Name:	Address:	Telephone No.:	Email:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

- **List Co-infections:**
  Indicate if the person has had a Hepatitis B and/or C diagnosis: Indicate the date of diagnosis. Was it an acute or chronic case?
  Sexually Transmitted Disease (STD): Specify which STD (chlamydia, gonorrhea, syphilis, HPV, herpes, other) and the date of diagnosis.

- **Partners:**
  List sex and needle sharing partners for the last year and spouses for the last 10 years for those persons you need help from ISDH to notify.

XIV. HIV TESTING HISTORY


XIV. HIV TESTING HISTORY

STATE USE ONLY Reviewed by (initials)

Date of interview/medical chart abstraction (mo/day/yr): ____/____/____

FIRST POSITIVE HIV TEST

Date of first positive HIV test (mo/day/yr): ____/____/____

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1 (first positive test) + ____ (# of negative tests during prior 2 years) = ____ (total # of tests in 2 years)

LAST NEGATIVE HIV TEST

Ever tested negative? Yes ☐ No ☐ Ref ☐ Unk ☐

Date of last negative HIV test (mo/day/yr): ____/____/____

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV

Antiretroviral use? Yes ☐ No ☐ Ref ☐ Unk ☐

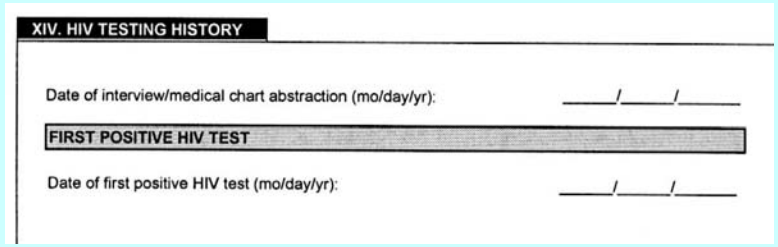
ARV medications taken: _____
(Show chart; continue in comments if necessary)

Date HAART use began (mo/day/yr): ____/____/____

Date HAART use ended (mo/day/yr): ____/____/____

First Positive HIV Test

- Enter the month, day, and year the testing history information is obtained from the patient and/or medical record.
- Enter month, day, and year of **first** positive Western Blot HIV test *(Note: This may be the current test you are reporting, or a previous positive test. If the individual reports a previous positive Western Blot test, that test should be referenced for the remainder of the questions, not the current positive test.)*


XIV. HIV TESTING HISTORY

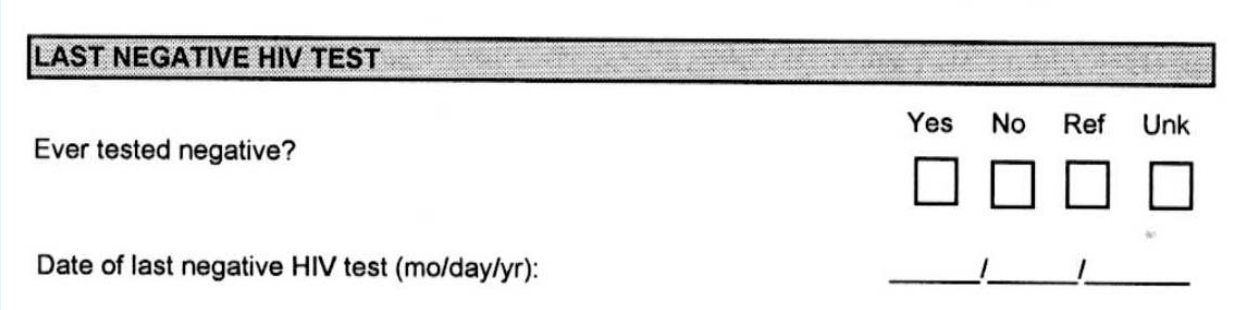
Date of interview/medical chart abstraction (mo/day/yr): ____/____/____

FIRST POSITIVE HIV TEST

Date of first positive HIV test (mo/day/yr): ____/____/____

Last Negative HIV Test

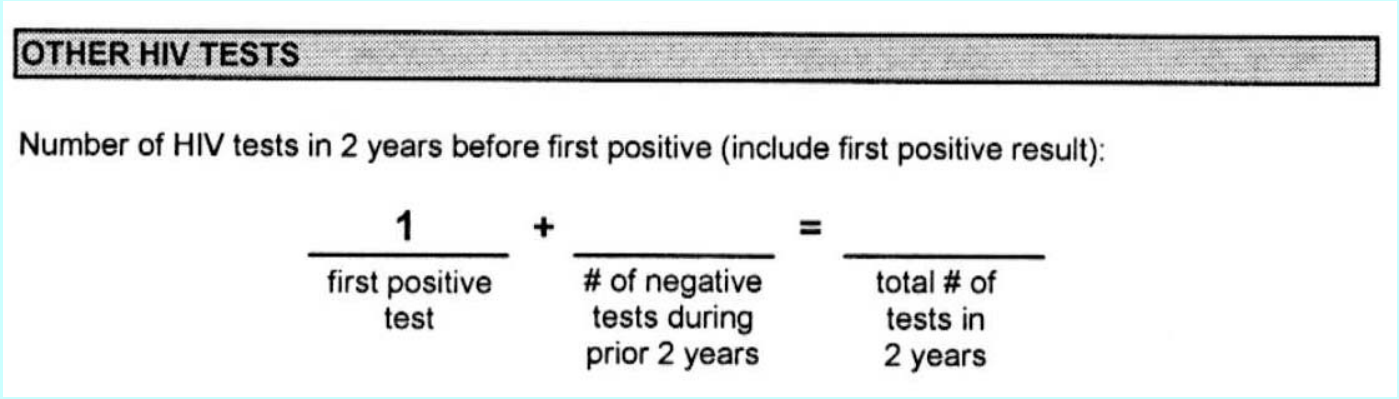
- Place an “X” in the appropriate box (Yes/No) if the individual has EVER had a negative HIV test result.
- Place an “X” in the Refused or Unknown box if appropriate.
- Enter the month, day, and year the individual **last** tested negative for HIV**.**



Other HIV Tests

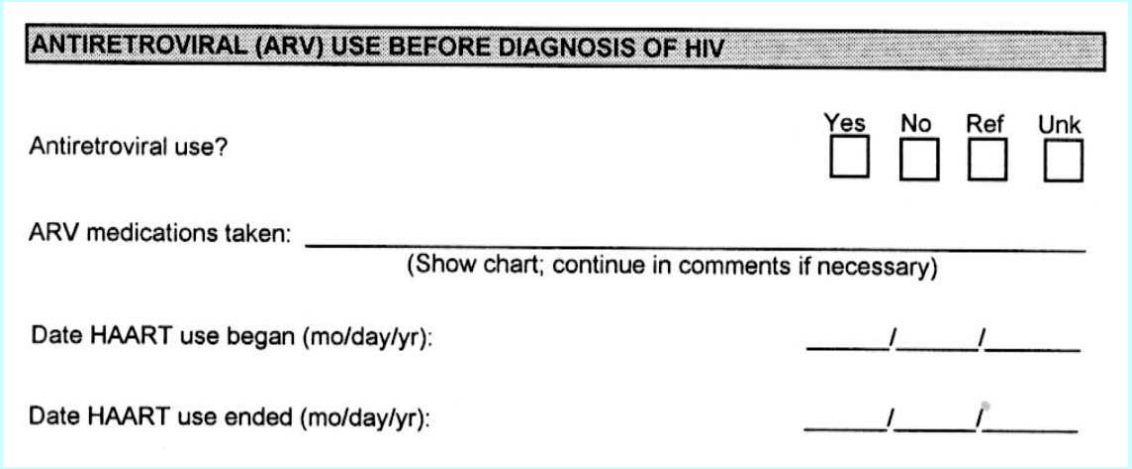
- Enter the total number of HIV tests the individual had in the two (2) years prior to his/her **first** positive Western Blot test result.

  (Note: This may be the current test you are reporting, or a previous positive test. If the individual reports a previous positive Western Blot test, that test should be referenced for the remainder of the questions, not the current positive test.)



Antiretroviral Use Before Diagnosis of HIV

- Place an "X" in the appropriate box (Yes, No, Refused, Unknown) for whether the individual has used Antiretroviral (ARV) medications in the six (6) months prior to the first positive Western Blot.
- List the ARV medications the individual has used. *(Show the patient a picture chart of HIV ARV medications. These charts can be obtained from the ISDH Division of HIV/STD.)*
- List the month, day, and year the individual first starting taking the ARV medications.
- List the month, day, and year the individual last used ARV medications, if he/she is not currently using ARV.



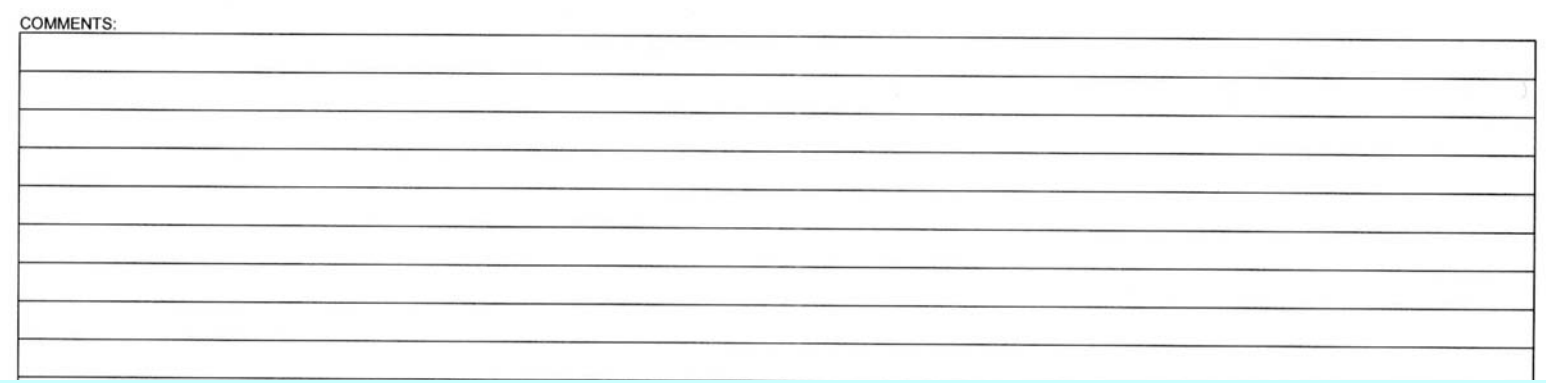
ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV

Antiretroviral use? Yes ☐ No ☐ Ref ☐ Unk ☐

ARV medications taken: _____
(Show chart; continue in comments if necessary)

Date HAART use began (mo/day/yr): _____/_____/_____

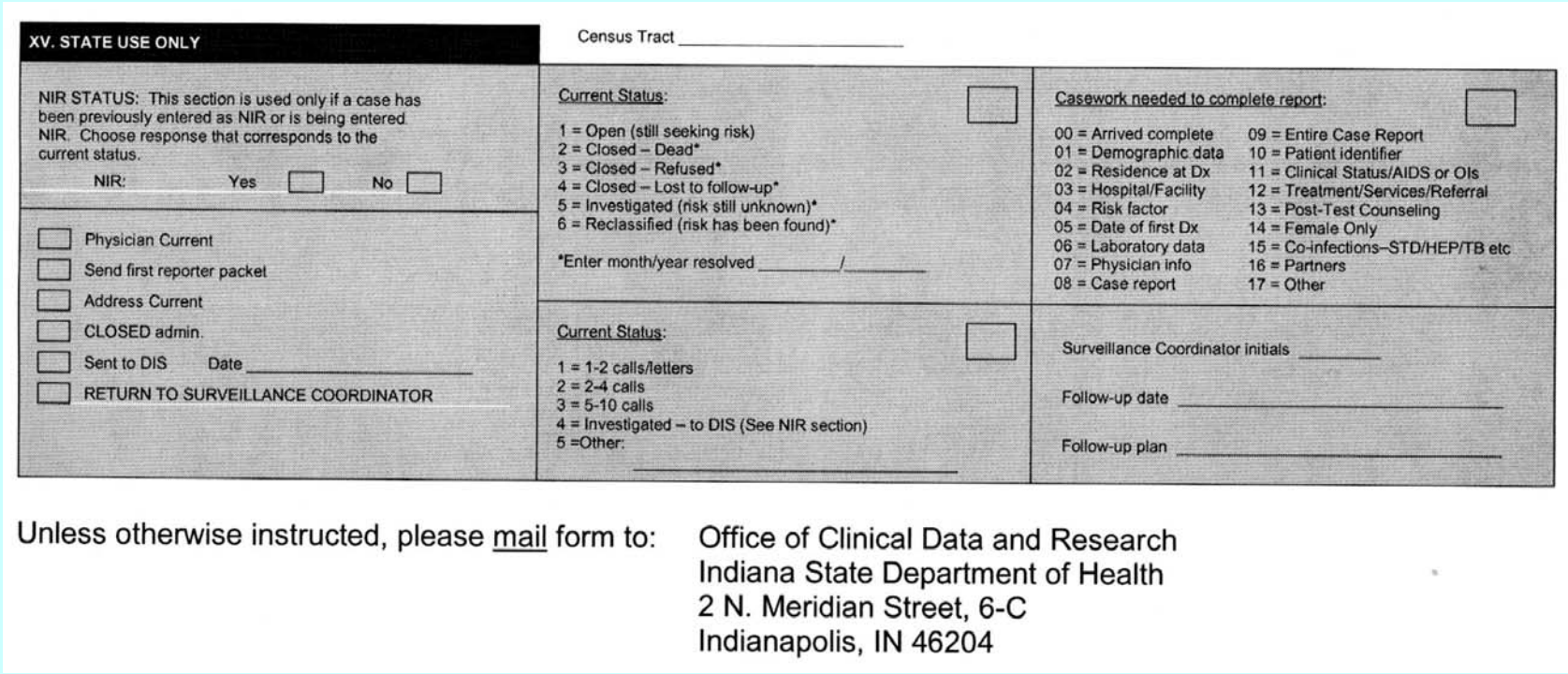
Date HAART use ended (mo/day/yr): _____/_____/_____



COMMENTS

- **Use this section for any other pertinent information such as:**
  Has spouse/partner been tested or reported?
  Has patient been referred to care coordination? If so, coordinator's name, location and phone number.
  Is patient from another state/country? If so, were they diagnosed there?
  Are there any reported symptoms, such as previous pneumonia, cancer, etc.?
  If patient has children, have they been tested? If positive, have they been reported?
  Expected date of release from jail or prison.
  List any other miscellaneous information you feel may be useful.

XIV. State Use Only



XV. STATE USE ONLY

Census Tract _____

NIR STATUS: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.

NIR: Yes ☐ No ☐

☐ Physician Current
☐ Send first reporter packet
☐ Address Current
☐ CLOSED admin.
☐ Sent to DIS Date _____
☐ RETURN TO SURVEILLANCE COORDINATOR

Current Status: ☐

1 = Open (still seeking risk)
2 = Closed – Dead*
3 = Closed – Refused*
4 = Closed – Lost to follow-up*
5 = Investigated (risk still unknown)*
6 = Reclassified (risk has been found)*

*Enter month/year resolved _____/_____

Current Status: ☐

1 = 1-2 calls/letters
2 = 2-4 calls
3 = 5-10 calls
4 = Investigated – to DIS (See NIR section)
5 =Other: _____

Casework needed to complete report: ☐

00 = Arrived complete	09 = Entire Case Report
01 = Demographic data	10 = Patient identifier
02 = Residence at Dx	11 = Clinical Status/AIDS or OIs
03 = Hospital/Facility	12 = Treatment/Services/Referral
04 = Risk factor	13 = Post-Test Counseling
05 = Date of first Dx	14 = Female Only
06 = Laboratory data	15 = Co-infections–STD/HEP/TB etc
07 = Physician info	16 = Partners
08 = Case report	17 = Other

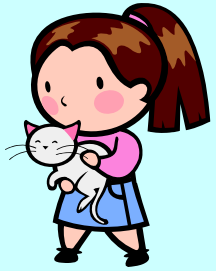
Surveillance Coordinator initials _____

Follow-up date _____

Follow-up plan _____

Unless otherwise instructed, please mail form to:

Office of Clinical Data and Research
Indiana State Department of Health
2 N. Meridian Street, 6-C
Indianapolis, IN 46204



If you are aware of an HIV-positive child under 13 years of age and/or a woman with HIV that just delivered, contact your surveillance department for assistance in completing the appropriate forms.

NOTE: Additional case report forms and other reporting information can be obtained from the ISDH Web site at:

www.statehealth.in.gov/programs/hivstd/index.htm

Then, click on Confidential Case Report Forms and then the Adult Case Report Form; print.

Mailing labels can also be obtained by calling (800) 376-2501.

Surveillance Contacts

Lake County **- (219) 755-3030**

Marion County **- (317) 221-2132**

All other counties**, call ISDH Surveillance toll free (800) 376-2501**