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

Reporting sex, race, ethnicity, and behavior allows us 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.
• Print the legal name. If known, put maiden names and aliases in parentheses.

• For Dept of Correction inmates, include both the name and 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. DEMOGRAPHIC INFORMATION

#### DIAGNOSTIC STATUS AT REPORT:
- 1 HIV Infection (not AIDS)
- 2 AIDS

#### AGE AT DIAGNOSIS:
- Years

#### DATE OF BIRTH:
- Month
- Day
- Year

#### CURRENT STATUS:
- Alive
- Dead
- Unk.

#### DATE OF DEATH:
- Month
- Day
- Year

#### STATE/TERRITORY OF DEATH:
- ___________________________

#### 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)
- 8 Other
- 9 Unk.

#### SEX (at birth):
- 1 Male
- 2 Female

#### SEX (current):
- 1 Male
- 2 Female

### Instructions:

- 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. **It may not be the patient’s current address** – 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.
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 first 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.

<table>
<thead>
<tr>
<th>IV. FACILITY OF FIRST DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
</tr>
<tr>
<td>City</td>
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<tr>
<td>State/Country</td>
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</tbody>
</table>

FACILITY SETTING (check one)

- 1 Public
- 2 Private
- 3 Federal
- 9 Unknown

FACILITY TYPE (check one)

- (A02.03) Physician, HMO
- (A02.04) HRSA Clinic
- (A02.05) Counseling & Testing Site
- (A02.08) Prenatal/OB clinic
- (A02) Hospital, Outpatient
- (A04.04) Case Mgt. Agency
- (A06.19) Correction facility
- (A04.05) Counseling & Testing Site
- (A01.01) Hospital, Inpatient
- (A04.02) Drug treatment center
- (A010) Other (specify):______________________
• Patient History is important in determining a person’s probable source of exposure to HIV.

• Indicate yes, no, or unknown 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.
• 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.
- 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

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

* 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?**

- [ ] Yes
- [ ] No
- [ ] 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.
• 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.
• 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

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.)*
**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.

![Last Negative HIV Test Form](image)
**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.)*

![Other HIV Tests](image)
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 started 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 Use Before Diagnosis of HIV Form](image-url)
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

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Current Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Open (still seeking risk)</td>
</tr>
<tr>
<td>2 = Closed - Dead*</td>
</tr>
<tr>
<td>3 = Closed - Refused*</td>
</tr>
<tr>
<td>4 = Closed - Lost to follow-up*</td>
</tr>
<tr>
<td>5 = Investigated (risk still unknown)*</td>
</tr>
<tr>
<td>6 = Reclassified (risk has been found)*</td>
</tr>
</tbody>
</table>

*Enter month/year resolved / |

<table>
<thead>
<tr>
<th>Casework needed to complete report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 = Arrived complete</td>
</tr>
<tr>
<td>01 = Demographic data</td>
</tr>
<tr>
<td>02 = Residence at Dx</td>
</tr>
<tr>
<td>03 = Hospital/Facility</td>
</tr>
<tr>
<td>04 = Risk factor</td>
</tr>
<tr>
<td>05 = Date of first Dx</td>
</tr>
<tr>
<td>06 = Laboratory data</td>
</tr>
<tr>
<td>07 = Physician info</td>
</tr>
<tr>
<td>08 = Case report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surveillance Coordinator Initials</th>
</tr>
</thead>
</table>

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