

**I. STATE/LOCAL USE ONLY**

Patient's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 (Last, First, M.I.)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**RETURN TO STATE/LOCAL HEALTH DEPARTMENT**

- Patient Identifier Information is not transmitted to CDC! -

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
 Centers for Disease Control and Prevention

**ADULT HIV/AIDS CONFIDENTIAL CASE REPORT**  
 (Patients ≥13 years of age at time of diagnosis)



**II. HEALTH DEPARTMENT USE ONLY**

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

DATE FORM COMPLETED:

Mo. Day Yr.

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

**DATE OF BIRTH:** Mo. Day Yr.

**CURRENT STATUS:** Alive Dead Unk.  1  2  9

**DATE OF DEATH:** Mo. Day Yr.

**STATE/TERRITORY OF DEATH:** \_\_\_\_\_

**SEX:**  1 Male  2 Female

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

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

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

**RESIDENCE AT DIAGNOSIS:**  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**IV. FACILITY OF DIAGNOSIS**

Facility Name: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Country: \_\_\_\_\_

**FACILITY SETTING** (check one)  
 1 Public  2 Private  3 Federal  9 Unk.

**FACILITY TYPE** (check one)  
 01 Physician, HMO  31 Hospital, Inpatient  
 88 Other (specify): \_\_\_\_\_

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 306(d) of the Public Health Service Act (42 USC 242m).

**V. PATIENT HISTORY**

**AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD** (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sex with female	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Injected nonprescription drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Specify: <input type="checkbox"/> 1 Factor VIII <input type="checkbox"/> 2 Factor IX <input type="checkbox"/> 8 Other (specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Bisexual male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transfusion recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transplant recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Mo. Yr. First: <input type="text"/> <input type="text"/> Last: <input type="text"/> <input type="text"/>			
• Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Worked in a health-care or clinical laboratory setting (specify occupation): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

**VI. LABORATORY DATA**

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

	Pos	Neg	Ind	Not Done	TEST DATE
					Mo. Yr.
• HIV-1 EIA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
• HIV-1/HIV-2 combination EIA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
• HIV-1 Western blot/IFA	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
• Other HIV antibody test (specify): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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

culture  antigen  PCR, DNA or RNA probe

• Other (specify): \_\_\_\_\_

**3. DETECTABLE VIRAL LOAD TEST:** (Record most recent test)

Test type*	COPIES/mL	Mo.	Yr.
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

\*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

**4. IMMUNOLOGIC LAB TESTS:**

**AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS**

	Mo.	Yr.
• CD4 Count _____ cells/μL	<input type="text"/>	<input type="text"/>
• CD4 Percent _____ %	<input type="text"/>	<input type="text"/>
First <200 μL or <14% _____ cells/μL	<input type="text"/>	<input type="text"/>
• CD4 Count _____ cells/μL	<input type="text"/>	<input type="text"/>
• CD4 Percent _____ %	<input type="text"/>	<input type="text"/>

• Date of last documented negative HIV test (specify type): \_\_\_\_\_ Mo. Yr.

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes No Unk.  1  0  9

Mo. Yr.

If yes, provide date of documentation by physician \_\_\_\_\_

**VII. STATE/LOCAL USE ONLY**

Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Medical Record No. \_\_\_\_\_  
 (Last, First, M.I.)  
 Hospital/Facility: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

- Patient identifier information is not transmitted to CDC! -

**VIII. CLINICAL STATUS**

CLINICAL RECORD REVIEWED:	Yes <input checked="" type="checkbox"/> 1	No <input type="checkbox"/> 0	ENTER DATE PATIENT WAS DIAGNOSED AS:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Mo. <input type="checkbox"/> <input type="checkbox"/>	Yr. <input type="checkbox"/> <input type="checkbox"/>	Symptomatic (not AIDS):	Mo. <input type="checkbox"/> <input type="checkbox"/>	Yr. <input type="checkbox"/> <input type="checkbox"/>
AIDS INDICATOR DISEASES			Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.	AIDS INDICATOR DISEASES			Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.
Candidiasis, bronchi, trachea, or lungs	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent term)	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Candidiasis, esophageal	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent term)	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Carcinoma, invasive cervical	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Lymphoma, primary in brain	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cryptococcosis, extrapulmonary	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	M. tuberculosis, pulmonary*	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	M. tuberculosis, disseminated or extrapulmonary*	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Pneumocystis carinii pneumonia	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
HIV encephalopathy	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Pneumonia, recurrent, in 12 mo. period	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Progressive multifocal leukoencephalopathy	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Histoplasmosis, disseminated or extrapulmonary	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Salmonella septicemia, recurrent	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Isosporiasis, chronic intestinal (>1 mo. duration)	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Toxoplasmosis of brain	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Kaposi's sarcoma	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Wasting syndrome due to HIV	<input checked="" type="checkbox"/> 1	NA	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

**IX. TREATMENT/SERVICES REFERRALS**

Has this patient been informed of his/her HIV infection? <input checked="" type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unk.	This patient is receiving or has been referred for:
This patient's partners will be notified about their HIV exposure and counseled by: <input checked="" type="checkbox"/> 1 Health department <input type="checkbox"/> 2 Physician/provider <input type="checkbox"/> 3 Patient <input type="checkbox"/> 9 Unknown	Yes No NA Unk. • HIV related medical services <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> - <input type="checkbox"/> 9 • Substance abuse treatment services <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 8 <input type="checkbox"/> 9
This patient received or is receiving:	This patient's medical treatment is primarily reimbursed by:
• Anti-retroviral therapy Yes No Unk. <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • PCP prophylaxis Yes No Unk. <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	<input checked="" type="checkbox"/> 1 Medicaid <input type="checkbox"/> 2 Private insurance/HMO <input type="checkbox"/> 3 No coverage <input type="checkbox"/> 4 Other Public Funding <input type="checkbox"/> 7 Clinical trial/government program <input type="checkbox"/> 9 Unknown
This patient has been enrolled at:	
Clinical Trial Clinic <input checked="" type="checkbox"/> 1 NIH-sponsored <input type="checkbox"/> 1 HRSA-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unknown <input type="checkbox"/> 9 Unknown	

**FOR WOMEN:** • This patient is receiving or has been referred for gynecological or obstetrical services:  1 Yes  0 No  9 Unknown  
 • Is this patient currently pregnant?  1 Yes  0 No  9 Unknown  
 • Has this patient delivered live-born infants?  1 Yes (if delivered after 1977, provide birth information below for the most recent birth)  0 No  9 Unknown

CHILD'S DATE OF BIRTH: Mo. Day Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hospital of Birth: _____ City: _____ State: _____	Child's Soudex: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Child's State Patient No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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**X. COMMENTS:** \_\_\_\_\_  
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Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, NE, Atlanta, GA 30333, ATTN: PRA (0625-0573). Do not send the completed form to this address.