



Florida Adult HIV/AIDS Confidential Case Report

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

Doc# 1 2 3 4

I. HEALTH DEPT USE ONLY

Document Source	New Investigation	Report Medium	Surveillance Method	State Number
A _____	yes no	FV M F Ph ET DK	A F P R U	
Report Status	New Update	Rptg. CHD City/Co: _____	Date form completed: ____/____/____	

II. PATIENT IDENTIFIER INFORMATION-data not transmitted to CDC (must be filled out completely)

Patient Name: _____ SS#: _____

Address: _____ City: _____ County: _____

State: _____ Zip: _____ Phone: () _____ City/County Patient Number _____

III. DEMOGRAPHIC INFORMATION - complete ALL fields

Diagnostic Status:	Sex at Birth:	Date of Birth:	Country of Birth:	Status:	Death:
<input type="checkbox"/> HIV <input type="checkbox"/> AIDS	<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____	<input type="checkbox"/> US <input type="checkbox"/> UNK <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Other _____	<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Date: ____/____/____ State/Terr of Death: _____

Ethnicity (select one): Hispanic Not Hispanic or Latino Unknown

Race: (select all that apply) Black/AA Asian Native American or Alaskan White Hawaiian/PI Unk

Residence at Diagnosis: Same as Current Street Address: _____

City: _____ County: _____ State/Country: _____ Zip: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____

Address: _____

City: _____

State/Country: _____ Zip: _____

FL

Facility Code: _____

Facility Setting (check one)

Public Private Federal Other

Provider Name _____

Provider Ph. No. (727) _____

Med. Rec. No: _____

Person Completing Form _____

Phone No. (727) _____

V. PATIENT HISTORY- complete ALL fields

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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injected non-prescription drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factor for hemophilia/coagulation disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify disorder: <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Other (Hemophilia A) (Hemophilia B) (Specify): _____			
HETEROSEXUAL relations with any of the following:			
Intravenous/Injection Drug User.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual male (applies to females only).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia/coagulation disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplant recipient with documented HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with AIDS or documented HIV infection, risk unspecified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received transfusion of blood/blood components (other than clotting factor) First Date: ____/____/____ Last Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received organ transplant, tissue or artificial insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worked in healthcare or clinical laboratory.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(specify occupation): _____			
Other documented risk (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test - mm/dd/yyyy)			HIV Detection Tests: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 NAT		
HIV-1/2 EIA			HIV-1 Qual PCR RNA		
HIV-1 Western Blot/IFA			HIV-1 P24 Antigen		
HIV-2 EIA			HIV-1 Qual PCR DNA		
Other			Other		
Viral Load Test: (most recent test- mm/dd/yyyy)			Immunologic Lab Test: (test date-mm/dd/yyyy)		
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date	
HIV-1 NASBA			CD4 Count: _____ cells/ul (_____ %)		
HIV-1 RT-PCR			First<200 or <14% of total lymphocytes		
HIV-1 bDNA			CD4 Count: _____ cells/ul (_____ %)		
Other					

Physician Diagnosis:

If HIV laboratory test were not documented, is HIV diagnosis documented by a physician? Yes No Unk

If yes, enter date of diagnosis (mm/dd/yyyy) _____

VII. CLINICAL STATUS

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date	Def.	Pres.		Initial DxDate	Def.	Pres.
	mm/dd/yy				mm/dd/yy		
Candidiasis, bronchi, trachea, or lungs	___/___/___	<input type="checkbox"/>		Lymphoma, Burkitt's (or equivalent term)	___/___/___	<input type="checkbox"/>	
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, immunoblastic (or equivalent terms)	___/___/___	<input type="checkbox"/>	
Carcinoma, invasive cervical	___/___/___	<input type="checkbox"/>		Lymphoma, primary in brain	___/___/___	<input type="checkbox"/>	
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___	<input type="checkbox"/>		M. tuberculosis, pulmonary *	___/___/___	<input type="checkbox"/>	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	___/___/___	<input type="checkbox"/>		M. tuberculosis, disseminated, or extrapulmonary *	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	___/___/___	<input type="checkbox"/>		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___	<input type="checkbox"/>		Pneumonia, recurrent, in 12 mo. period	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	___/___/___	<input type="checkbox"/>		Progressive multifocal leukoencephalopathy	___/___/___	<input type="checkbox"/>	
Histoplasmosis, disseminated, or extrapulmonary	___/___/___	<input type="checkbox"/>		Salmonella septicemia, recurrent	___/___/___	<input type="checkbox"/>	
Isosporiasis, chronic intestinal (>1 mo. duration)	___/___/___	<input type="checkbox"/>		Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	Wasting syndrome due to HIV	___/___/___	<input type="checkbox"/>	

Def. = definitive diagnosis Pres. = presumptive diagnosis * RVCT Case Number _____

VIII. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? Yes No Unk

This patient's partners will be notified about their HIV exposure and counseled by: 1-Health Dept 2-Physician/Provider 3-Patient 9-Unk

Is patient receiving or been referred for:	This patient received or is receiving:
HIV related medical services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Antiretroviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Substance Abuse treatment services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	PCP prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Is patient enrolled in a clinical trial? 1-NIH sponsored 2-Other 3-None 9-Unknown

This patient has enrolled at (Clinic): 1-HRSA sponsored 2-Other 3-None 9-Unknown

At the time of HIV/AIDS diagnosis, medical treatment is primarily reimbursed by: Medicaid Pvt. Ins/HMO Other: Unk

FOR WOMEN ONLY

Is patient receiving or been referred for obstetrical or gynecological services? Yes No Unk

Is patient currently pregnant? Yes No Unk

If YES, EDC (due date) : ___/___/___

Has patient delivered a live-born infant? Yes No Unk

CHILDREN OF PATIENT (enter info on last child)

Date of Birth: _____ Hospital _____ City: _____ State: _____ Zip: _____

Child's Name: _____ Child's Soundex: _____ Child's State No: _____

IX. LOCAL FIELDS (health department use only)

PRISM # _____ NIR STATUS: NIR_OP _____ NIR OP DATE _____

DOC # _____ NIR_CL _____ NIR CL DATE: _____

CONTACT STATENO(S): _____ NIR_RE _____ NIR RE DATE: _____

OTHER RISKS: A ___ B/C ___ D ___ F ___ M ___ V ___ J ___ INITIALS _____ SOURCE CODE A _____

HEPATITIS: A ___ B ___ C ___ Other ___ Unknown _____

X. COMMENTS: (about partner(s), if relocated - from what state/area, STD or hepatitis history, drug use, sex abuse, psych, or jail history?)

Does patient have any alias names, DOBs, SSNs, etc.?

If your patient is pregnant, have you referred her to a high risk prenatal clinic? Where?

Please include any documentation that might be helpful to the health department (e.g. lab tests, out of state information, etc.)

Please mail this report in a double envelope marked "CONFIDENTIAL" to Beth Sudduth, MPH, Pinellas County Health Department, Surveillance- Room 148, 205 Dr. M.L. King St. N, St. Petersburg, FL 33701