

**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  1 Dead  2 Unk.  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 308(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 disorder: (Hemophilia A) (Hemophilia B) (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
First Mo. Yr. <input type="text"/> <input type="text"/> Last Mo. Yr. <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	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
(specify occupation): _____			

**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"/>
• 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"/>
• 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"/>
• 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"/>

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

culture  antigen  PCR, DNA or RNA probe  Mo.  Yr.

• Other (specify): \_\_\_\_\_  Mo.  Yr.

**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"/>

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

**4. IMMUNOLOGIC LAB TESTS:**

**AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS**

• CD4 Count \_\_\_\_\_ cells/μL  Mo.  Yr.

• CD4 Percent \_\_\_\_\_ %  Mo.  Yr.

First <200 μL or <14%  Mo.  Yr.

• CD4 Count \_\_\_\_\_ cells/μL  Mo.  Yr.

• CD4 Percent \_\_\_\_\_ %  Mo.  Yr.

• 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?  1 Yes  0 No  9 Unk.

If yes, provide date of documentation by physician \_\_\_\_\_ Mo. Yr.

