



Date form completed (enter all dates in mm/dd/yyyy format)

I. Health Department Use Only

Soundex Code				Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No				Reporting Health Department				State Patient Number			
Surveillance Method				Report Medium				Field Visit				Mailed			
A	F	P	R	U	Report Medium	Field Visit	Mailed	Faxed	Phone	E. Transfer	Diskette	Other State/City/County Number			

Date received at MDH: _____ | Document source: _____ or source code: A _____

II. Patient Name (last name, first name, and middle initial), Locating Information and Identification

Patient's Name				Alias							
Home Phone No.				Cell Phone No.				Work Phone No.			
Address				City		County		State		ZIP Code	
Social Security Number: _____ - _____ - _____						Other Locating: _____					

III. Demographic Information

Diagnostic Status at Report <input type="checkbox"/> HIV infection (not AIDS) <input type="checkbox"/> AIDS	Age at Diagnosis Years (HIV)	Date of Birth Month Day Year	Alias Date of Birth Month Day Year	Country of Birth <input type="checkbox"/> United States <input type="checkbox"/> Other, specify below _____	Language Spoken Interpreter Needed? Yes No State/Territory of Death
	Years (AIDS)				
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Amer. Indian/Alaska Nat. <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pac. Isl. <input type="checkbox"/> White <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Date of Death Month Day Year	
Current Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Is this person a healthcare industry worker? ____ YES ____ NO If YES, enter occupation: Location: _____				

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Separated <input type="checkbox"/> Other _____	Partner / Spouse Information Name: _____ Age: _____ Name: _____ Age: _____ Emergency Contact: _____ Phone: _____
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Residence at HIV Diagnosis Same as current address

Address	City	County	State/Country	ZIP Code
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Residence at AIDS Diagnosis Same as current address

Address	City	County	State/Country	ZIP Code
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IV. Facility and Provider of Diagnosis / Facility of Care

Name of Fac. Of Diagnosis: _____ Facility Setting <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Federal if Federal, specify setting: _____	City, County, State, Zip Code: _____ Facility Type <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Screening, Diagnostic, Referral Agency <input type="checkbox"/> Other: _____ (name)
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Facility / Provider of Care Name		Provider Specialty
Provider Phone No.	Medical Record No.	

Person Completing Form _____ Phone No. _____

V. Patient History

Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories):	YES	NO	UNK.
• Sex with male			
• Sex with female			
• Injected non-prescription drugs			
• Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: _____ Date received (mm/dd/yyyy) _____			
• HETEROSEXUAL relations with any of the following:			
○ Intravenous/injection drug user			
○ Bisexual male			
○ Person with hemophilia/coagulation disorder			
○ Transfusion recipient with documented HIV infection (consider documenting reason in the Comments section)			
○ Transplant recipient with documented HIV infection (consider documenting reason in the Comments section)			
○ Person with AIDS or documented HIV infection, risk not specified			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section) First date received _____ Last date received _____			
• Received transplant of tissue/organs or artificial insemination			
• Worked in a healthcare or clinical laboratory setting _____ If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____			
• Other documented risk			
• No identified risk factor (NIR)			

VI. Laboratory Data

HIV Antibody Tests at Diagnosis				First Test Date mm/dd/yyyy	HIV Detection Test: (EARLIEST known test)			Test Date - mm/dd/yyyy
HIV-1 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV-1 RNA PCR (Qual)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
HIV-1 IFA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV-1 DNA PCR (Qual)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
HIV-1 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV-1 P24 Antigen	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
HIV-1/2 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV-1 Culture	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
HIV-2 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV-2 Culture	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
Other: _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Indet		HIV NAT	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	
Date of last documented negative HIV test ____ / ____ / ____				Specify type of test:		Location of Neg. test:		
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If YES, enter date of diagnosis: ____ / ____ / ____		Physician Name:		

Viral Load Tests (record most recent and earliest)

Type (select # from below)	Copies/μL	Log	Collection Date (mm/dd/yyyy)
1 - NASBA			____ / ____ / ____
2 - RT-PCR (stand)			____ / ____ / ____
3 - RT-PCR (ultrasen)			____ / ____ / ____
4 - bDNA - version 2			____ / ____ / ____
5 - bDNA - version 3			____ / ____ / ____
6 - Other			____ / ____ / ____

Immunologic Lab Tests (record additional CD4 tests in Comments section)

At or closest to current diagnostic status	CD4 count	cells/μL	Collection Date (mm/dd/yyyy)
	CD4 percent	%	____ / ____ / ____
First <200μL or <14%	CD4 count	cells/μL	____ / ____ / ____
	CD4 percent	%	____ / ____ / ____

VII. Clinical Status

Clinical Record Reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enter date patient was diagnosed as:	<u>Asymptomatic</u> (including acute retroviral syndrome and persistent generalized lymphadenopathy)	mm/dd/yyyy	<u>Symptomatic</u> (not AIDS)	mm/dd/yyyy
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Def. = definitive diagnosis			Pres. = presumptive diagnosis			Def. = definitive diagnosis			Pres. = presumptive diagnosis		
AIDS Indicator Diseases		Initial Dx		Initial Date	AIDS Indicator Diseases		Initial Dx		Initial Date		
	Def.	Pres.	mm/dd/yyyy			Def.	Pres.	mm/dd/yyyy			
Candidiasis, bronchi, trachea, or lungs			__/__/__	Lymphoma, Burkitt's (or equivalent)				__/__/__			
Candidiasis, esophageal			__/__/__	Lymphoma, immunoblastic (or equivalent)				__/__/__			
Carcinoma, invasive cervical			__/__/__	Lymphoma, primary in brain				__/__/__			
Coccidioidomycosis, disseminated or extrapulmonary			__/__/__	<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary				__/__/__			
Cryptococcosis, extrapulmonary			__/__/__	<i>M. tuberculosis</i> , pulmonary				__/__/__			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)			__/__/__	<i>M. tuberculosis</i> , disseminated or extrapulmonary				__/__/__			
Cytomegalovirus disease (other than in liver, spleen, or nodes)			__/__/__	<i>Mycobacterium</i> , of other/unidentified species, disseminated or extrapulmonary				__/__/__			
Cytomegalovirus retinitis (with loss of vision)			__/__/__	<i>Pneumocystis carinii</i> pneumonia				__/__/__			
HIV encephalopathy			__/__/__	Pneumonia, recurrent, in 12 mo. period				__/__/__			
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis			__/__/__	Progressive multifocal leukoencephalopathy				__/__/__			
Histoplasmosis, disseminated or extrapulmonary			__/__/__	Salmonella septicemia, recurrent				__/__/__			
Isosporiasis, chronic intestinal (>1 mo. duration)			__/__/__	Toxoplasmosis of brain				__/__/__			
Kaposi's sarcoma			__/__/__	Wasting syndrome due to HIV				__/__/__			

VIII. Treatment/Services Referrals

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health Department <input type="checkbox"/> Physician/Provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown
HIV related medical services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antiretroviral therapy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
This patient is receiving or has been referred for: Substance abuse treatment services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	This patient received or is receiving: PCP prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Has this patient been referred to an Infectious Disease (ID) Clinic? Yes No Unknown

If YES:

Clinic Name:

Clinic Phone No.

Provider Name:

Last Appointment Date / Time:

Next Appointment Date / Time:

IX. For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services: Yes No Unknown

Is this patient currently pregnant? Yes **Due Date:** No Unknown

Has this patient delivered live-born infants? Yes No Unknown

Children of Patient (record information below; if more than 3 children please use the Comments section)

Child's Name	Child's Date of Birth
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Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name

City	County	State	Zip
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Country

Child's Name	Child's Date of Birth
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Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name

City	County	State	Zip
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Country

Child's Name	Child's Date of Birth
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Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name

City	County	State	Zip
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Country

X. Comments

XI. Other Testing

Condition	Tested		Test Result	Diagnosis Date mm/dd/yyyy	Facility/State of Diagnosis	Has patient been treated?
Syphilis	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Gonorrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Chlamydia	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Hepatitis B Surface Antigen	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Hepatitis C	<input type="checkbox"/> No	<input type="checkbox"/> Yes				