

I. Patient Identification (record all dates as mm/dd/yyyy)

*First Name		*Middle Name		*Last Name		Last Name Soundex			
Alternate Name Type (ex: Alias, Married)			*First Name		*Middle Name		*Last Name		
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary				*Current Address, Street			Address Date ____/____/____		
*Phone ()		City		County		State/Country		*ZIP Code	
*Medical Record Number				*Other ID Type				*Number	

U.S. Department of Health
and Human Services**Adult HIV Confidential Case Report Form**
(Patients ≥13 years of age at time of diagnosis) *Information NOT transmitted to CDCCenters for Disease Control
and Prevention (CDC)**II. Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no.0920-0573 Exp. 02/28/2026

Date Received at Health Department ____/____/____		eHARS Document UID		State Number	
Reporting Health Dept—City/County			City/County Number		
Document Source		Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown			
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown		Report Medium ☐ 1-Field visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 6-CD/disk			

III. Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ()					
*Street Address								
City		County		State/Country		*ZIP Code		
Facility Type <u>Inpatient:</u> ☐ Hospital ☐ Adult HIV clinic ☐ Other, specify _____ <u>Outpatient:</u> ☐ Private physician's office ☐ CTS ☐ STD clinic ☐ Other, specify _____ <u>Screening, Diagnostic, Referral Agency:</u> ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____								
Date Form Completed ____/____/____			*Person Completing Form			*Phone ()		

IV. Patient Demographics (record all dates as mm/dd/yyyy)

Sex ☐ Male ☐ Female ☐ Unknown/Undetermined		Country of Birth ☐ US ☐ Other/US dependency (specify) _____			
Date of Birth ____/____/____			Alias Date of Birth ____/____/____		
Vital Status ☐ 1-Alive ☐ 2-Dead		Date of Death ____/____/____		State of Death	
Sexual Orientation ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Additional sexual orientation (specify) _____ ☐ Declined to answer ☐ Unknown					
Date Identified ____/____/____					
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown				Expanded Ethnicity	
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown				Expanded Race	

V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if <u>SAME</u> as current address							
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary							
*Street Address							
City		County		State/Country		*ZIP Code	

Public reporting burden of this collection of information is estimated to average 20 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, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

VI. Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Check if <u>SAME</u> as facility providing information			
Facility Name			*Phone ()
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type <i>Inpatient:</i> ☐ Hospital ☐ Other, specify _____	<i>Outpatient:</i> ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	<i>Screening, Diagnostic, Referral Agency:</i> ☐ CTS ☐ STD clinic ☐ Other, specify _____	<i>Other Facility:</i> ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
*Provider Name		*Provider Phone ()	Specialty

VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ **Pediatric Risk (enter in Comments)**

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: _____ Date received ____/____/____	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____	
Other documented risk (include detail in Comments) _____	☐ Yes ☐ No ☐ Unknown

VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? <i>If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section</i>	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset ____/____/____	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? <i>If YES, describe:</i> _____ Date of evidence ____/____/____	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses					
Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary ¹	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary ¹	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

¹If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays	
TEST ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-2 IA	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ☐ Positive ☐ Negative ☐ Indeterminate	Collection Date ____/____/____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) (cont)

TEST ☐ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result Overall: ☐ Reactive ☐ Nonreactive	Collection Date ____/____/____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive HIV-1/2 Ab: ☐ Reactive ☐ Nonreactive	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ³ Overall interpretation: ☐ Reactive ☐ Nonreactive ☐ Index Value _____	Collection Date ____/____/____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level Index Value _____	
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated Index Value _____	
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated Index Value _____	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ⁴ Overall interpretation: ☐ HIV positive, untypable ☐ HIV-1 positive with HIV-2 cross-reactivity ☐ HIV-2 positive with HIV-1 cross-reactivity	
☐ HIV negative ☐ HIV indeterminate ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV-1 positive ☐ HIV-2 positive	
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate Collection Date ____/____/____	
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 WB	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ☐ Positive ☐ Negative ☐ Indeterminate	Collection Date ____/____/____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
HIV Detection Tests	
TEST ☐ HIV-1/2 RNA NAAT (Qualitative)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ☐ HIV-1 ☐ HIV-2 ☐ Both (HIV-1 and HIV-2) ☐ HIV, not differentiated (HIV-1 or HIV-2) ☐ Neither (negative)	Collection Date ____/____/____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1 RNA NAAT (Qualitative and Quantitative)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result Qualitative: ☐ Reactive ☐ Nonreactive	Collection Date ____/____/____
Analyte results: HIV-1 Quantitative: ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit	
Copies/mL _____ Log _____	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ☐ Positive ☐ Negative ☐ Indeterminate	Collection Date ____/____/____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
TEST ☐ HIV-1 RNA/DNA NAAT (Quantitative) ☐ HIV-2 RNA/DNA NAAT (Quantitative)	
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Result ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit ☐ Not detected Copies/mL _____ Log _____	
Collection Date ____/____/____	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	
Drug Resistance Tests (Genotypic)	
TEST ☐ HIV-1 Genotype (Unspecified)	Test Brand Name/Manufacturer _____
Lab Name _____	Facility Name _____
Provider Name _____	Collection Date ____/____/____
Immunologic Tests (CD4 count and percentage)	
CD4 count _____ cells/ μ L CD4 percentage _____ %	Collection Date ____/____/____
Test Brand Name/Manufacturer _____	Lab Name _____
Facility Name _____	Provider Name _____
Documentation of Tests	
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown	
If YES, provide specimen collection date of earliest positive test result for this algorithm ____/____/____	
<i>Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.</i>	
Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? ☐ Yes ☐ No ☐ Unknown	
If YES, provide date of diagnosis by physician ____/____/____	
Date of last documented negative HIV test result (before HIV diagnosis date) ____/____/____	
Specify type of test: _____	
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider ² ☐ Lab test, self-collected sample	

²Results not directly observed by a provider should be recorded in HIV Testing History.³Complete the overall interpretation and the analyte results.⁴Always complete the overall interpretation. Complete the analyte results when available.

X. Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown		This patient's partners will be notified about their HIV exposure and counseled by ☐ 1-Health dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown	
Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments) ☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __/__/__			
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 ☐ No ☐ Unknown	
Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown			
For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)			
*Child's Name		Child's Date of Birth __/__/__	
Child's Last Name Soundex		Child's State Number	
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone () ()	
Facility Type <u>Inpatient:</u> ☐ Hospital ☐ Other, specify _____		<u>Outpatient:</u> ☐ Other, specify _____	
		<u>Other Facility:</u> ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____	
*Street Address		*ZIP Code	
City		County	
		State/Country	

XI. Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other			Date patient reported information ____/____/____		
Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown					
If yes, reason for ARV use (select all that apply)					
☐ HIV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		
☐ PrEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		
☐ PEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		
☐ PMTCT	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		
☐ HBV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		
☐ Other (specify reason) _____					
	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____		

XII. HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other		Date patient reported information ____/____/____	
Ever had previous positive HIV test result? ☐ Yes ☐ No ☐ Unknown		Date of first positive HIV test result ____/____/____	
Was the first positive test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown			
Ever had a negative HIV test result? ☐ Yes ☐ No ☐ Unknown		Date of last negative HIV test result (if date is from a lab test with test type, enter in Lab Data section) ____/____/____	
Was the last negative test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown			
Number of negative HIV test results within the 24 months before the first positive test result __ __ ☐ Unknown			
How many of these negative test results were from self-tests performed by the patient? __ __ ☐ Unknown			

XIII. Comments

CHECK OOS STATE: _____	If pregnant, list EDD (due date): ____/____/____
DOC# _____	
Link with e-HARS stateno(s): _____	

XIV. *Local/Optional Fields

STARS# _____		NIR OP		Date: ____/____/____	
Other Risks: A B/C D F M V J O		NIR CL		Date: ____/____/____	
Hepatitis: A B C Other UNKnown		NIR RE		Date: ____/____/____	
Test & Treat (Yes/No)		Initials (3) _____		Source code: _____	

This report to 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. Information in CDC's National HIV 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, 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).