

Completing the Indiana HIV Case Report Form
Indiana State Department of Health
Office of Clinical Data and Research
Last Updated –12-12-2013

General Reminders

- ✓ All case report forms should be legibly written in black or blue ink.
- ✓ All case report forms should be submitted within 72 hours of notifying the patient of their positive status. If the patient does not return for results, the case report should be sent at that time.
- ✓ Perinatal exposure report forms should be sent immediately.
- ✓ All case report forms should be mailed to (Or other entity as outlined in the attached algorithm.);
 - Office of Clinical Data and Research
Indiana State Department of Health
2 North Meridian Street, Section 6-C
Indianapolis, Indiana 46209
- ✓ All case report forms should be mailed in the provided pink envelope or double enveloped with the word “confidential” written on both the interior and exterior envelopes.
- ✓ Please call us with any questions that you might have at **(317) 233-7406**.

Section I: Patient Information

- Provide the patient’s legal name. If known, please include maiden names or aliases in parentheses.
- The Social Security number should be included in order to prevent duplication.
- The date the form was completed should be clearly noted.

Section II: State Health Department Use Only

- This will be completed by the health department in the processing of the report.

Section III: Demographic Information

- Indicate if the patient is infected with HIV or has progressed to an AIDS diagnosis.
- Clearly indicate date of birth.
- If the patient is deceased please include this information including the date of death and the location (state/territory), of death.
- Be sure to indicate both the sex at birth and current sex.
- Include both the patient’s race and ethnicity.
- If the patient was born outside of the United States please indicate the country of birth.
- If available, please include the current height and weight.
- Enter the residence at FIRST diagnosis. This might be different than the patient’s current address. Please also include any other states where the patient may have lived or been treated since their original HIV diagnosis.

Section IV: Facility of Diagnosis

- Include the full name of the facility at FIRST diagnosis including the city and state or country. This may be a different facility than the one completing the current form.
- If known, indicate the type of facility.

Section V: Physician/Provider Completing Form

- This section should be based on the facility/provider completing the form.
- Indicate the physician or provider’s first and last name as well a phone number where they can be reached.
- If available, include the medical record number for the patient.
- Indicate the hospital/facility/provider where the patient is receiving care at the time of completion.
- Indicate the name of the individual completing the form and a telephone number where they can be reached.

Section VI: Patient History

- The information from this section is used to determining the probable mode of exposure to HIV.
- This section should be completed based upon information obtained from the patient; do not guess.

Section VII: Laboratory Data

- Mark the type of test(s) used for the diagnosis and the collection date. There must be a confirmed lab result meets CDC guidelines for a HIV diagnosis.
- Include information about other test(s) performed related to HIV disease and include collection dates for each of those test(s).
- Please attach a copy of all HIV related laboratory reports including genotype and/or phenotype to the case report form upon submission.

Section VIII: Clinical Status

- The information in this section will assist in determining an AIDS diagnosis.
- Indicate if this information was obtained from a chart abstraction or clinical record review.
- Only mark those conditions with a definitive diagnosis and the date of this diagnosis.

Section IX: Treatment/Services

- Indicate if the patient has been informed and counseled as to their HIV status.
- Indicate the method by which the patient's partner(s) will be notified of their HIV status.
- Note any referrals given to the patient.
- Indicate if the patient has been previously or is currently being treated for HIV disease.
- Indicate the method by which their case is being reimbursed to the provider.

Section X: Female Patient Information

- Indicate if the patient is currently pregnant.
- Include the expected date of delivery (EDD).
- Include the name and/or facility where the patient is receiving care for the current pregnancy.
- Indicate if the pregnancy care provider is aware of the patient's HIV status.
- Indicate if the patient has received information about antiretroviral medications in relationship to this pregnancy. Note if she declined medications.
- List the name(s) and date(s) of birth of any children born since the patient was diagnosed with HIV disease. Note the name of the hospital, the city, and the state where the child(ren) was born. Note if the child(ren) have been tested for HIV disease and their current status.
- If the mother recently gave birth please determine and make note if a perinatal exposure form was completed and submitted.

Section XI: HIV Testing History

- Information used to complete this portion of the form should be collected via patient interview if possible. If this is not possible, medical chart abstraction may be used.

Section XII: Post-Test Counseling

- The individual providing the positive test result MUST post-test counsel the patient. This MUST include informing the patient of Indiana law requiring they may not donate blood, plasma, organs, and/or tissue. They also must inform all sex and needle sharing partners before they engage in sexual and/or needle sharing activities. Subsequent medical providers should also reinforce this and make documentation of such in the patient record.
- Indicate the date this post test counseling occurred and the full name and telephone where the individual that provided the counseling can be reached.

Section XIII: Coinfections and Partner Information

- Indicate any known coinfections that the patient may have and the date with which it was diagnosed.
- Should the patient request partner services please provide the name, address, telephone number, and email address of any sexual and/or needle sharing partners in the space provided. If you need additional space please write that in the comments section.

Comments

- The comments section should be used to report any other pertinent information not collected within the form itself. Examples might include;
 - Has the spouse/partner been tested or reported?
 - If the patient has children, have the children been tested or reported?
 - Are there any signs or symptoms of disease noted by the patient or provider (pneumonia, cancers, etc.)?