I. PATIENT INFORMATION

Patient's Name (Last, First, M.I.): ______ Phone No.: ( ) ______

Address: ______ City: ______ County: ______ State: ______ Zip Code: ______

RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security No.: ______ *- Patient identifier information is not transmitted to CDC! -*

INDIANA STATE DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

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

State Form 51201 (R2/4-07)

II. STATE HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED: Month ☐☐ Day ☐☐ Year ☐☐

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. DEMOGRRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)
- 1 HIV Infection (not AIDS) — **AGE AT DIAGNOSIS:** ☐☐ Years
- 2 AIDS — ☐☐ Years

DATE OF BIRTH: Month ☐☐ Day ☐☐ Year ☐☐

CURRENT STATUS: Alive 1; Dead 2; Unk. 9

DATE OF DEATH: Month ☐☐ Day ☐☐ Year ☐☐

STATE/TERRITORY OF DEATH: ______

SEX (at birth): 1 Male; 2 Female

SEX (current): ☐ Male; ☐ Female

ETHNICITY (select one): 1 Hispanic or Latino; 2 Not Hispanic or Latino; 9 Unknown

RACE (select one or more): ☐ American Indian or Alaska Native; ☐ Asian; ☐ Black or African American; ☐ Native Hawaiian/or Other Pacific Islander; ☐ White; ☐ Unknown

COUNTRY OF BIRTH:
- 1 U.S.
- 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) ______
- 8 Other (specify): ______
- 9 Unk.

RESIDENCE AT DIAGNOSIS:

City: ______ County: ______ State/Country: ______ Zip Code: ☐☐☐☐☐ - ☐☐☐☐

LIVED IN ANY OTHER STATE/COUNTRY?: State: ______ Country: ______

IV. FACILITY OF FIRST DIAGNOSIS

______
Facility Name

______
City

______
State/Country

FACILITY SETTING (check one)

1 Public; 2 Private; 3 Federal; 9 Unknown

FACILITY TYPE (check one)

☐ (A02.03) Physician, HMO	☐ (A02.08) Prenatal/OB clinic
☐ (A04.04) Case Mgt. Agency	☐ (A06.19) Correction facility
☐ (A02.04) HRSA Clinic	☐ (A01.01) Hospital, Inpatient
☐ (A04.05) Counseling & Testing Site	☐ (A02) Hospital, Outpatient
☐ (A04.02) Drug treatment center	☐ (A010) Other (specify): ______

V. PATIENT HISTORY

BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON HAD (Respond to ALL categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (Specify): ______

	Yes	No	Unk.
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9

First Mo. ☐☐ Yr. ☐☐ Last Mo. ☐☐ Yr. ☐☐

	Yes	No	Unk.
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting (specify occupation): ______	1	0	9

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos.	Neg.	Ind.	Not Done	Mo.	Day	Yr.
• HIV-1 EIA	1	0	-	☐	☐☐	☐☐	☐☐
• HIV-1/HIV-2 combination EIA	1	0	-	☐	☐☐	☐☐	☐☐
• HIV-1 Western blot/1FA	1	0	8	☐	☐☐	☐☐	☐☐
• NAT (Nucleic Acid Test)	1	0	-	☐	☐☐	☐☐	☐☐

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

	Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe	☐☐	☐☐	☐☐
• NAT (Nucleic Acid Test)	☐☐	☐☐	☐☐

3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (specify type): ______ Mo. ☐☐ Day ☐☐ Yr. ☐☐

4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes 1; No 0; Unk. 9; Mo. ☐☐ Day ☐☐ Yr. ☐☐

5. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

	Value	Month	Day	Year
• CD4 Count	☐ . ☐☐☐ cells/μL	☐☐	☐☐	☐☐
• CD4 Percent	☐☐ %	☐☐	☐☐	☐☐

First <200 μL or <14%

	Value	Month	Day	Year
• CD4 Count	☐ . ☐☐☐ cells/μL	☐☐	☐☐	☐☐
• CD4 Percent	☐☐ %	☐☐	☐☐	☐☐

6. RESISTANCE TESTS:

	Month	Day	Year
• Genotyping (send copy)	☐☐	☐☐	☐☐
• Phenotyping (send copy)	☐☐	☐☐	☐☐

7. **CTR / OPSCAN #** ______

VII. PHYSICIAN INFORMATION

Physician's Name: ________________ (Last, First, M.I.) Phone No.: ( ) ________ Medical Record No.: ________

Name of Facility or Practice: ________________ Complete Address: ________________

Email: ________________ FAX: ( ) ________ Person Completing Form: ________________ Phone No.: ( ) ________

- Physician identifier information is not transmitted to CDC! -

VIII. VIRAL LOAD DATA*

Laboratory Name: ________________

bDNA _____ NASBA _____ RNA PCR _____ Results ____________ Date ___/___/___

bDNA _____ NASBA _____ RNA PCR _____ Results ____________ Date ___/___/___

IX. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: ASYMPTOMATIC (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo [ ] Day [ ] Yr. [ ]

Symptomatic (not AIDS): Mo [ ] Day [ ] Yr. [ ]

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Pres.	Initial Date Mo.	Day	Yr.
1) Candidiasis, bronchi, trachea, or lungs	1	NA			
2) Candidiasis, esophageal	1	2			
3) Carcinoma, invasive cervical	1	NA			
4) Coccidioidomycosis, disseminated or extrapulmonary	1	NA			
5) Cryptococcosis, extrapulmonary	1	NA			
6) Cryptosporidiosis, chronic intestinal (>1 Mo. duration)	1	NA			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			
8) Cytomegalovirus retinitis (with loss of vision)	1	2			
9) HIV encephalopathy	1	NA			
10) Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			
11) Histoplasmosis, disseminated or extra pulmonary	1	NA			
12) Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			
13) Kaposi's sarcoma	1	2			
14) Lymphoma, Burkitt's (or equivalent term)	1	NA			
15) Lymphoma, immunoblastic (or equivalent term)	1	NA			
16) Lymphoma, primary in brain	1	NA			
17) *Mycobacterium avium* complex or M. Kansasii, disseminated or extrapulmonary	1	2			
18) *M. tuberculosis, pulmonary**	1	2			
19) *M. tuberculosis*, disseminated or extrapulmonary*	1	2			
20) *Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary	1	2			
21) *Pneumocystis carinii* pneumonia	1	2			
22) *Pneumonia*, recurrent, in 12 mo. period	1	2			
23) Progressive multifocal leukoencephalopathy	1	NA			
24) Salmonella septicemia, recurrent	1	NA			
25) Toxoplasmosis of brain	1	2			
26) Wasting syndrome due to HIV	1	NA			

Def. = definitive diagnosis Pres. = presumptive diagnosis

*RVCT CASE NO.: [ ]

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

X. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:

[1] DIS (Local Health Department) [2] Physician/provider [3] Patient [9] Unk.

[ ] ISDH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

	Yes	No	Unk.
HIV-related medical services	1	0	9
Substance abuse treatment services	1	0	9
Mental health services	1	0	9

Specify: ________________

This patient received or is receiving:

	Yes	No	Unk.
Anti-retroviral therapy	1	0	9
PCP prophylaxis	1	0	9

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is <u>primarily</u> reimbursed by:

[1] Medicaid [2] Private insurance/HMO

[3] No coverage [4] Other Public Funding

[7] Clinical trial/ government program [9] Unknown

XI. POST-TEST COUNSELING

Has the patient been told not to donate blood, plasma, organs, or other body tissue? ……… [1] Yes [0] No [9] Unk. Date ________________

Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior? ……… [1] Yes [0] No [9] Unk. Date ________________

MUST COMPLETE:

Name of person that provided post-test counseling ______________________________ Telephone No.: ( ) __________________

XII. FOR FEMALES ONLY

Is the patient currently pregnant? ……… [1] Yes [0] No [9] Unk. Date Due [|] [|] [|]

Obstetrician/NP/Clinic/Family Doctor: ______________________________ Telephone No.: ( ) ______________________________

Is the above provider aware of her HIV status? ……… [1] Yes [0] No [9] Unk.

Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ……… [1] Yes [0] No [9] Unk. [ ] Information offered and patient declined.

Name of Child *(Most recent birth after 1977)*: ______________________________ Date of Birth: _________/_________/__________

Hospital Name: ______________________________ City: ____________________ State: ____________________

Has the child been tested for HIV? Yes [ ] No [ ] If yes, what was the result? ______________________ Was the child born before the mother's last negative HIV test? Yes [ ] No [ ]

XIII. COINFECTION/PARTNERS

COINFECTIONS:	Yes	No	Unk.	Diagnosis Date	Acute	Chronic
Hepatitis B ………	[ ]	[ ]	[ ]	______________	[ ]	[ ]
Hepatitis C ………	[ ]	[ ]	[ ]	______________		
Sexually Transmitted Disease (STD) ………	[ ]	[ ]	[ ]	______________	Specify STD: ______________	
Sexually Transmitted Disease (STD) ………	[ ]	[ ]	[ ]	______________	Specify STD: ______________	
Sexually Transmitted Disease (STD) ………	[ ]	[ ]	[ ]	______________	Specify STD: ______________	

Information on all spouses for last 10 years and any sex or needle-sharing partners for the last year that you would like for the ISDH to help notify:

Name:	Address:	Telephone No.:	Email:
1. ______________	______________	______________	______________
2. ______________	______________	______________	______________
3. ______________	______________	______________	______________

XIV. HIV TESTING HISTORY

STATE USE ONLY Reviewed by (initials) [ ]

Date of interview/medical chart abstraction (mo/day/yr): ______/______/_______

FIRST POSITIVE HIV TEST

Date of first positive HIV test (mo/day/yr): ______/______/_______

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1 (first positive test) + ________ (# of negative tests during prior 2 years) = ________ (total # of tests in 2 years)

LAST NEGATIVE HIV TEST

Ever tested negative? Yes [ ] No [ ] Ref [ ] Unk [ ]

Date of last negative HIV test (mo/day/yr): ______/______/_______

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV

Antiretroviral use? Yes [ ] No [ ] Ref [ ] Unk [ ]

ARV medications taken: ______________________________
(Show chart; continue in comments if necessary)

Date HAART use began (mo/day/yr): ______/______/_______

Date HAART use ended (mo/day/yr): ______/______/_______

COMMENTS:

(Attach additional sheet if needed.)

XV. STATE USE ONLY

Census Tract ________________________

NIR STATUS: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.

NIR: Yes ☐ No ☐

☐ Physician Current
☐ Send first reporter packet
☐ Address Current
☐ CLOSED admin.
☐ Sent to DIS Date ________________________
☐ RETURN TO SURVEILLANCE COORDINATOR

Current Status: ☐

1 = Open (still seeking risk)
2 = Closed – Dead*
3 = Closed – Refused*
4 = Closed – Lost to follow-up*
5 = Investigated (risk still unknown)*
6 = Reclassified (risk has been found)*

*Enter month/year resolved _________/_________

Current Status: ☐

1 = 1-2 calls/letters
2 = 2-4 calls
3 = 5-10 calls
4 = Investigated – to DIS (See NIR section)
5 =Other: ___________________________________

Casework needed to complete report: ☐

00 = Arrived complete	09 = Entire Case Report
01 = Demographic data	10 = Patient identifier
02 = Residence at Dx	11 = Clinical Status/AIDS or OIs
03 = Hospital/Facility	12 = Treatment/Services/Referral
04 = Risk factor	13 = Post-Test Counseling
05 = Date of first Dx	14 = Female Only
06 = Laboratory data	15 = Co-infections–STD/HEP/TB etc
07 = Physician info	16 = Partners
08 = Case report	17 = Other

Surveillance Coordinator initials _________

Follow-up date ___________________________________

Follow-up plan ___________________________________

Unless otherwise instructed, please mail form to:

Office of Clinical Data and Research
Indiana State Department of Health
2 N. Meridian Street, 6-C
Indianapolis, IN 46204