

**Completing the new  
Adult/Adolescent  
HIV and AIDS  
Confidential Case Report Form**




Office of Clinical Data and Research  
Indiana State Department of Health  
Toll free 800-376-2501 or 317-233-7406

# HIV/AIDS Case Report Forms

Accurate, thorough, case reports provide demographic information regarding the spread of the HIV/AIDS infection.

Reporting sex, race, ethnicity, and behavior allows us to gear programs toward specific populations and areas of need.

Case reports need to be initiated within **72 hours after notifying the person they are positive. If a person does not return for their test result, send in the report at that time.** All HIV-infected pregnant women must be reported immediately. All babies born to HIV-infected or AIDS-diagnosed mothers must be reported immediately after birth. **Please indicate the baby's pediatrician.**

I. PATIENT INFORMATION														
Patient's Name (Last, First, MI): _____										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 -						
 <b>INDIANA STATE DEPARTMENT OF HEALTH</b> <b>ADULT HIV/AIDS CONFIDENTIAL CASE REPORT</b> (Patients ≥ 13 years of age at time of diagnosis) State Form 51201 (R2/4-07)														
B. STATE HEALTH DEPARTMENT USE ONLY														
DATE FORM COMPLETED: Month: [ ] Day: [ ] Year: [ ]			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)		AGE AT DIAGNOSIS: [ ] Years		DATE OF BIRTH: Month: [ ] Day: [ ] Year: [ ] [ ] [ ]		CURRENT STATUS: 1 2 3			DATE OF DEATH: Month: [ ] Day: [ ] Year: [ ] [ ] [ ]		STATE/TERRITORY OF DEATH: _____			
1 HIV Infection (not AIDS) 2 AIDS		[ ] Years		[ ] [ ] [ ] [ ]		[ ] [ ] [ ]			[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]			
SEX (at birth): 1 Male 2 Female		ETHNICITY (select one): 1 Hispanic or Latino 2 Not Hispanic or Latino 3 Unknown		RACE (select one or more): American Indian or Alaska Native Native Hawaiian/Other Pacific Islander Asian White Black or African American Unknown		COUNTRY OF BIRTH: 1 U.S. 2 U.S. Dependencies and Possessions (incl. Puerto Rico) 3 Other (Specify): _____ 4 Unknown								
SEX (current): 1 Male 2 Female		[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ]		[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]				
RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]														
LIVED IN ANY OTHER STATE/COUNTRY: State: _____ County: _____														
IV. FACILITY OF FIRST DIAGNOSIS						V. PATIENT HISTORY								
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 06) Prenatal/OB clinic [ ] (A04 04) Case Mgr. Agency [ ] (A06 18) 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): _____						BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON HAD (Respond to ALL categories): • Sex with male: [ ] Yes [ ] No [ ] Unk • Sex with female: [ ] Yes [ ] No [ ] Unk • Injected nonprescription drugs: [ ] Yes [ ] No [ ] Unk • Received clotting factor for hemophilia/coagulation disorder: [ ] Yes [ ] No [ ] Unk Specify: [ ] Factor VII (hemophilia A) [ ] Factor IX (hemophilia B) [ ] Other (Specify): _____ • HETEROSEXUAL relations with any of the following: • Intravenous/injection drug user: [ ] Yes [ ] No [ ] Unk • Menstrual male: [ ] Yes [ ] No [ ] Unk • Person with hemophilia/coagulation disorder: [ ] Yes [ ] No [ ] Unk • Transfusion recipient with documented HIV infection: [ ] Yes [ ] No [ ] Unk • Transplant recipient with documented HIV infection: [ ] Yes [ ] No [ ] Unk • Person with AIDS or documented HIV infection, risk not specified: [ ] Yes [ ] No [ ] Unk • Received transfusion of blood/blood components (other than clotting factor): [ ] Yes [ ] No [ ] Unk Specify: First [ ] Last [ ] • Received transplant of tissues/organs or artificial insertion: [ ] Yes [ ] No [ ] Unk • Worked in a health-care or clinical laboratory setting (Specify occupation): [ ] Yes [ ] No [ ] Unk								
VI. LABORATORY DATA														
1. HIV ANTIBODY TESTS AT DIAGNOSIS (Indicate test type): • HIV-1 EIA: [ ] Pos [ ] Neg [ ] Ind [ ] Not Done [ ] Mo [ ] Day [ ] Yr [ ] • HIV-1/2/3 combination EIA: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] • HIV-1 Western Blot/IFA: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] • NAT (Nucleic Acid Test): [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 2. POSITIVE HIV DETECTION TEST: (Report positive test) • HIV PCR, DNA, or RNA probe: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] • NAT (Nucleic Acid Test): [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (Specify type): [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes [ ] No [ ] Unk [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]						7. CTR / OPSCAN # _____								

<b>I. PATIENT INFORMATION</b>			
Patient's Name (Last, First, M.I.): _____		Phone No.: ( ) _____	
Address: _____	City: _____	County: _____	State: _____ Zip Code: _____
<b>RETURN TO STATE/LOCAL HEALTH DEPARTMENT</b>		Social Security No.: _____	- Patient identifier information is not transmitted to CDC! -

- **Print the legal name. If known, put maiden names and aliases in parentheses.**
- **For Dept of Correction inmates, include both the name and offender number. It is NOT enough to list just the offender number.**
- **Enter the social security number. It is used to make certain we have the correct person and to prevent duplication of patients.**

**DATE FORM COMPLETED:**

Month	Day	Year
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

**REPORT SOURCE:**

- **Enter the date the report is completed.**
- **ISDH will complete the report source.**

## II. STATE HEALTH DEPARTMENT USE ONLY

**II. STATE HEALTH DEPARTMENT USE ONLY**

<p>DATE FORM COMPLETED:</p> <p>Month      Day      Year</p> <p><input type="text"/> <input type="text"/>    <input type="text"/> <input type="text"/>    <input type="text"/> <input type="text"/></p>			<p><b>SOUNDEX CODE:</b></p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>			<p><b>REPORT STATUS:</b></p> <p><input type="checkbox"/> 1 New Report</p> <p><input type="checkbox"/> 2 Update</p>		<p><b>REPORTING HEALTH DEPARTMENT:</b></p> <p>State: _____</p> <p>City/County: _____</p>				<p>State Patient No.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>City/County Patient No.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>			
<p><b>REPORT SOURCE:</b> <input type="text"/> <input type="text"/></p>															

III. DEMOGRAPHIC INFORMATION											
<b>DIAGNOSTIC STATUS AT REPORT:</b> (check one) <input type="checkbox"/> 1 HIV Infection (not AIDS) <input type="checkbox"/> 2 AIDS		<b>AGE AT DIAGNOSIS:</b> <input type="text"/> <input type="text"/> Years <input type="text"/> <input type="text"/> Years		<b>DATE OF BIRTH:</b> Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>		<b>CURRENT STATUS:</b> <input type="checkbox"/> 1 Alive <input type="checkbox"/> 2 Dead <input type="checkbox"/> 9 Unk.		<b>DATE OF DEATH:</b> Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>		<b>STATE/TERRITORY OF DEATH:</b> _____	
<b>SEX (at birth):</b> <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female		<b>ETHNICITY (select one):</b> <input type="checkbox"/> 1 Hispanic or Latino <input type="checkbox"/> 2 Not Hispanic or Latino <input type="checkbox"/> 9 Unknown		<b>RACE (select one or more):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown				<b>COUNTRY OF BIRTH:</b> <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) _____ <input type="checkbox"/> 8 Other (specify): _____ <input type="checkbox"/> 9 Unk.			

- **Indicate whether the person is infected with HIV or has progressed to an AIDS diagnosis.**
- **Enter the date of birth correctly and legibly.**
- **Indicate if the person is alive or deceased. If deceased, enter the date of death and the state/territory where the person died.**
- **Mark the sex at birth and the current sex.**
- **Indicate both the ethnicity and the race(s) of the person.**
- **Complete the **Country of Birth**. If born outside of the United States, write in the country.**

<b>RESIDENCE AT DIAGNOSIS:</b> City: _____ County: _____ State/Country: _____ Zip Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>LIVED IN ANY OTHER STATE/COUNTRY?:</b> State: _____ Country: _____

- **Enter the residence at first diagnosis. It may not be the patient's current address – include the county, state/country if outside United States and zip code.**
- **Indicate any other states/countries where person may have lived. Enter this information even if it was prior to their diagnosis.**

**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)

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

- **Enter the entire name of the facility where the first positive HIV test was collected. Include the city and state/country of the facility.**
- **The facility of first diagnosis may be different from the facility where the form is being completed.**
- **Indicate if the facility is public, private, federal, or you do not know.**
- **Indicate the facility type.**

## 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 .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Sex with female .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Injected nonprescription drugs .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Received clotting factor for hemophilia/coagulation disorder .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
Specify disorder: <input type="text" value="1"/> Factor VIII (Hemophilia A) <input type="text" value="2"/> Factor IX (Hemophilia B) <input type="text" value="8"/> Other (Specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Bisexual male .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Person with hemophilia/coagulation disorder .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Transfusion recipient with documented HIV infection .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Transplant recipient with documented HIV infection .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Person with AIDS or documented HIV infection, risk not specified .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Received transfusion of blood/blood components (other than clotting factor) .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
First <input type="text" value="Mo."/> <input type="text" value="Yr."/> Last <input type="text" value="Mo."/> <input type="text" value="Yr."/>			
• Received transplant of tissue/organs or artificial insemination .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
• Worked in a health-care or clinical laboratory setting .....	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="9"/>
(specify occupation): _____			

- Patient History is important in determining a person's probable source of exposure to HIV.
- Indicate yes, no, or unknown for all bullet points.  
**Ask the person, do not guess.**



- Indicate the type of test used for diagnosis; the result; and the month, day, and year of the test. There must be a positive Western Blot (WB) or physician's diagnosis for an HIV diagnosis.
- If there is only a positive EIA/ELISA with a negative or indeterminate WB and NO physician's diagnosis, DO NOT complete a case report form. For a negative WB, depending on risky behavior, offer an appropriate retesting timeframe. A WB that is indeterminate should be repeated.
- Indicate the date of the last negative HIV test.
- If a physician wants to document an HIV diagnosis without test results to back the diagnosis, he/she must indicate the month, day, and year that the diagnosis was determined. **Indicate in the comment section why the diagnosis is being made.**
- Indicate CD4 results and genotype/phenotype information in the appropriate boxes.
- **Counseling and Testing Sites: You must indicate the CTR/OPSCAN Number on line #7.**

VI. LABORATORY DATA											
<b>1. HIV ANTIBODY TESTS AT DIAGNOSIS:</b> (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/IFA.....					1	0	8				
• NAT (Nucleic Acid Test) .....					1	0	-				
<b>2. POSITIVE HIV DETECTION TEST:</b> (Record earliest test)									Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe .....											
• NAT (Nucleic Acid Test) .....											
<b>3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST</b> (specify type): .....									Mo.	Day	Yr.
<b>4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN?</b> .....					Yes	No	Unk.		Mo.	Day	Yr.
					1	0	9				
<b>5. IMMUNOLOGIC LAB TESTS:</b> (At or closest to current diagnostic status)									Month	Day	Year
• CD4 Count .....											
• CD4 Percent .....											
First <200 $\mu$ L or <14%									Month	Day	Year
• CD4 Count .....											
• CD4 Percent .....											
<b>6. RESISTANCE TESTS:</b>									Month	Day	Year
• Genotyping (send copy) .....											
• Phenotyping (send copy) .....											
<b>7. CTR / OPSCAN #</b> .....											

**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! -

- **Legibly print the physician's first name and last name and the phone number where the physician can be reached.**
- **Please include the medical record number, if available.**
- **Indicate the Hospital/Facility where the patient/client is receiving care at the time the form is completed. Indicate the email address and fax number of the facility.**
- **Indicate legibly the first name and last name of the person completing this form and the phone number where they can be reached.**

**VIII. VIRAL LOAD DATA\***

Laboratory Name: \_\_\_\_\_

bDNA \_\_\_\_\_

NASBA \_\_\_\_\_

RNA PCR \_\_\_\_\_

Results \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

bDNA \_\_\_\_\_

NASBA \_\_\_\_\_

RNA PCR \_\_\_\_\_

Results \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- **Indicate the laboratory that ran the viral load test. Mark the type of test run, the result, and the date the blood was drawn/collected.**

- Information listed here will define an AIDS diagnosis.
- Be sure of the diagnosis and the date of diagnosis. Be certain there is a definitive diagnosis for those that do not allow a presumptive diagnosis.

IX. CLINICAL STATUS													
CLINICAL RECORD REVIEWED	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 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.
<p><u>AIDS INDICATOR DISEASES</u></p> <p>Initial Diagnosis      Initial Date</p> <p>Def.    Pres.    Mo.    Day    Yr.</p> <p>1) Candidiasis, bronchi, trachea, or lungs ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>2) Candidiasis, esophageal ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>3) Carcinoma, invasive cervical ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>4) Coccidioidomycosis, disseminated or extrapulmonary ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>5) Cryptococcosis, extrapulmonary ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>6) Cryptosporidiosis, chronic intestinal (&gt;1 Mo. duration) ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>7) Cytomegalovirus disease (other than in liver, spleen, or nodes) ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>8) Cytomegalovirus retinitis (with loss of vision) ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>9) HIV encephalopathy ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>10) Herpes simplex: chronic ulcer(s) (&gt;1 mo. duration); or bronchitis, pneumonitis or esophagitis ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>11) Histoplasmosis, disseminated or extra pulmonary ... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>12) Isosporiasis, chronic intestinal (&gt;1 mo. duration) .... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>13) Kaposi's sarcoma ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>						<p><u>AIDS INDICATOR DISEASES</u></p> <p>Initial Diagnosis      Initial Date</p> <p>Def.    Pres.    Mo.    Day    Yr.</p> <p>14) Lymphoma, Burkitt's (or equivalent term) ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>15) Lymphoma, immunoblastic (or equivalent term)..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>16) Lymphoma, primary in brain ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>17) <i>Mycobacterium avium</i> complex or <i>M. Kansasi</i>..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>18) <i>M. tuberculosis, pulmonary</i>* ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>19) <i>M. tuberculosis</i>, disseminated or extrapulmonary* ... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>20) <i>Mycobacterium</i>, of other species or unidentified species,disseminated or extrapulmonary ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>21) <i>Pneumocystis carinii</i> pneumonia ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>22) <i>Pneumonia</i>, recurrent, in 12 mo. period ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>23) Progressive multifocal leukoencephalopathy ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>24) Salmonella septicemia, recurrent ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>25) Toxoplasmosis of brain ..... <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>26) Wasting syndrome due to HIV ..... <input type="checkbox"/> 1    NA    <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>							
Def. = definitive diagnosis			Pres. = presumptive diagnosis			*RVCT CASE NO.: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
<p>• 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? <input type="checkbox"/> 1 Yes    <input type="checkbox"/> 0 No    <input type="checkbox"/> 9 Unknown</p>													

**X. TREATMENT/SERVICES REFERRALS**

<p>Has this patient been informed of his/her HIV infection? ..... <input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unk.</p> <p>This patient's partners will be notified about their HIV exposure and counseled by:</p> <p><input type="checkbox"/> 1 DIS (Local Health Department) <input type="checkbox"/> 2 Physician/provider <input type="checkbox"/> 3 Patient <input type="checkbox"/> 9 Unk.</p> <p><input type="checkbox"/> ISDH Surveillance office needs to notify DIS</p>		<p>This patient is receiving or has been referred for:</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">Unk.</td> </tr> <tr> <td>• HIV-related medical services.....</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 9</td> </tr> <tr> <td>• Substance abuse treatment services.....</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 9</td> </tr> <tr> <td>• Mental health services.....</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 9</td> </tr> </table> <p>Specify: _____</p>		Yes	No	Unk.	• HIV-related medical services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	• Substance abuse treatment services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	• Mental health services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9																
	Yes	No	Unk.																															
• HIV-related medical services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9																															
• Substance abuse treatment services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9																															
• Mental health services.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9																															
<p>This patient received or is receiving:</p> <table border="0"> <tr> <td>▪ Anti-retroviral therapy .....</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">Unk.</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 9</td> </tr> <tr> <td>▪ PCP prophylaxis ...</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">Unk.</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 9</td> </tr> </table>	▪ Anti-retroviral therapy .....	Yes	No	Unk.		<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	▪ PCP prophylaxis ...	Yes	No	Unk.		<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	<p>This patient has been enrolled at:</p> <table border="0"> <tr> <td style="text-align: center;"><u>Clinical Trial</u></td> <td style="text-align: center;"><u>Clinic</u></td> </tr> <tr> <td><input type="checkbox"/> 1 NIH-sponsored</td> <td><input type="checkbox"/> 1 HRSA-sponsored</td> </tr> <tr> <td><input type="checkbox"/> 2 Other</td> <td><input type="checkbox"/> 2 Other</td> </tr> <tr> <td><input type="checkbox"/> 3 None</td> <td><input type="checkbox"/> 3 None</td> </tr> <tr> <td><input type="checkbox"/> 9 Unknown</td> <td><input type="checkbox"/> 9 Unknown</td> </tr> </table>	<u>Clinical Trial</u>	<u>Clinic</u>	<input type="checkbox"/> 1 NIH-sponsored	<input type="checkbox"/> 1 HRSA-sponsored	<input type="checkbox"/> 2 Other	<input type="checkbox"/> 2 Other	<input type="checkbox"/> 3 None	<input type="checkbox"/> 3 None	<input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 9 Unknown	<p>This patient's medical treatment is <u>primarily</u> reimbursed by:</p> <table border="0"> <tr> <td><input type="checkbox"/> 1 Medicaid</td> <td><input type="checkbox"/> 2 Private insurance/HMO</td> </tr> <tr> <td><input type="checkbox"/> 3 No coverage</td> <td><input type="checkbox"/> 4 Other Public Funding</td> </tr> <tr> <td><input type="checkbox"/> 7 Clinical trial/ government program</td> <td><input type="checkbox"/> 9 Unknown</td> </tr> </table>	<input type="checkbox"/> 1 Medicaid	<input type="checkbox"/> 2 Private insurance/HMO	<input type="checkbox"/> 3 No coverage	<input type="checkbox"/> 4 Other Public Funding	<input type="checkbox"/> 7 Clinical trial/ government program	<input type="checkbox"/> 9 Unknown
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<input type="checkbox"/> 7 Clinical trial/ government program	<input type="checkbox"/> 9 Unknown																																	

- **Indicate if the person has been informed of his/her diagnosis.**
- **Indicate who will notify partners.**
- **Specify Mental Health Service referrals. Indicate for what purpose: specify bipolar, schizophrenia, paranoia, depression, non-injection drug use, alcohol abuse, suicidal tendencies, etc.**
- **Complete all sections regarding treatment accurately and completely.**

- The person providing the positive test result **MUST** post-test counsel the patient. This **MUST** include informing him/her that there are laws that say they may not donate blood, plasma, organs or tissue, **AND** that they **MUST** inform all sex and needle sharing partners **BEFORE** they engage in any sexual or needle sharing acts. However, it is important that **ALL** subsequent health care providers reinforce this point and document it in their medical records.
- Indicate the first and last name of the person who did the post-test counseling and the phone number where they can be reached.

XI. POST-TEST COUNSELING							
Has the patient been told not to donate blood, plasma, organs, or other body tissue? .....	<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 0	No	<input type="checkbox"/> 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? .....	<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 0	No	<input type="checkbox"/> 9	Unk.	Date _____
<b>MUST COMPLETE:</b>							
Name of person that provided post-test counseling _____	Telephone No.: (    ) _____						

## COMPLETE THIS SECTION FOR ALL FEMALES

XII. FOR FEMALES ONLY	
Is the patient currently pregnant? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unk.                        Date Due <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Obstetrician/NP/Clinic/Family Doctor: _____	Telephone No.: (    ) _____
Is the above provider aware of her HIV status? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unk.
Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unk. <input type="checkbox"/> Information offered and patient declined.
Name of Child ( <i>Most recent birth after 1977</i> ): _____	Date of Birth: ____/____/____
Hospital Name: _____	City: _____ State: _____
Has the child been tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No                        If yes, what was the result? _____	Was the child born before the mother's last negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No

- **Indicate if the patient is currently pregnant.**
- **Enter the date of expected delivery.**
- **Indicate the name and phone number of the health care provider for this pregnancy.**
- **Indicate if the health care provider is or is not aware of the patient's HIV status.**
- **Indicate if the patient has received information on antiretroviral medications in relationship to pregnancy. Indicate if she declined medications.**
- **List the name of the most recent birth since 1977 and his/her birth date.**
- **Indicate the name of the hospital, city, and state where the child was born. Has the child been tested? List the result. Indicate if this child was born before the mother's last negative test.**

**XIII. COINFECTION/PARTNERS**

COINFECTIONS:	Yes	No	Unk.	Diagnosis Date	Acute	Chronic
Hepatitis B .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sexually Transmitted Disease (STD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	
Sexually Transmitted Disease (STD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	
Sexually Transmitted Disease (STD) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	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. _____	_____	_____	_____

- **List Co-infections:**

**Indicate if the person has had a Hepatitis B and/or C diagnosis: Indicate the date of diagnosis. Was it an acute or chronic case?**

**Sexually Transmitted Disease (STD): Specify which STD (chlamydia, gonorrhea, syphilis, HPV, herpes, other) and the date of diagnosis.**

- **Partners:**

**List sex and needle sharing partners for the last year and spouses for the last 10 years for those persons you need help from ISDH to notify.**



# XIV. HIV TESTING HISTORY

XIV. HIV TESTING HISTORY		STATE USE ONLY	Reviewed by (initials)
Date of interview/medical chart abstraction (mo/day/yr): _____/_____/_____		<b>LAST NEGATIVE HIV TEST</b>	
<b>FIRST POSITIVE HIV TEST</b>		Ever tested negative? Yes No Ref Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date of first positive HIV test (mo/day/yr): _____/_____/_____		Date of last negative HIV test (mo/day/yr): _____/_____/_____	
<b>OTHER HIV TESTS</b>		<b>ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV</b>	
Number of HIV tests in 2 years before first positive (include first positive result):		Antiretroviral use? Yes No Ref Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
$\frac{1}{\text{first positive test}} + \frac{\text{\# of negative tests during prior 2 years}}{\text{total \# of tests in 2 years}} =$		ARV medications taken: _____ (Show chart, continue in comments if necessary)	
		Date HAART use began (mo/day/yr): _____/_____/_____	
		Date HAART use ended (mo/day/yr): _____/_____/_____	

## First Positive HIV Test

- Enter the month, day, and year the testing history information is obtained from the patient and/or medical record.
- Enter month, day, and year of **first** positive Western Blot HIV test (*Note: This may be the current test you are reporting, or a previous positive test. If the individual reports a previous positive Western Blot test, that test should be referenced for the remainder of the questions, not the current positive test.*)

XIV. HIV TESTING HISTORY	
Date of interview/medical chart abstraction (mo/day/yr):	_____/_____/_____
<b>FIRST POSITIVE HIV TEST</b>	
Date of first positive HIV test (mo/day/yr):	_____/_____/_____

## Last Negative HIV Test

- Place an “X” in the appropriate box (Yes/No) if the individual has EVER had a negative HIV test result.
- Place an “X” in the Refused or Unknown box if appropriate.
- Enter the month, day, and year the individual **last** tested negative for HIV.

LAST NEGATIVE HIV TEST				
Ever tested negative?	Yes	No	Ref	Unk
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last negative HIV test (mo/day/yr):	____/____/____			

## Other HIV Tests

- Enter the total number of HIV tests the individual had in the two (2) years prior to his/her **first** positive Western Blot test result.

*(Note: This may be the current test you are reporting, or a previous positive test. If the individual reports a previous positive Western Blot test, that test should be referenced for the remainder of the questions, not the current positive test.)*

### OTHER HIV TESTS

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

$$\frac{1}{\text{first positive test}} + \frac{\text{\# of negative tests during prior 2 years}}{\text{\# of negative tests during prior 2 years}} = \frac{\text{total \# of tests in 2 years}}{\text{total \# of tests in 2 years}}$$

## Antiretroviral Use Before Diagnosis of HIV

- Place an “X” in the appropriate box (Yes, No, Refused, Unknown) for whether the individual has used Antiretroviral (ARV) medications in the six (6) months prior to the first positive Western Blot.
- List the ARV medications the individual has used. (*Show the patient a picture chart of HIV ARV medications. These charts can be obtained from the ISDH Division of HIV/STD.*)
- List the month, day, and year the individual first starting taking the ARV medications.
- List the month, day, and year the individual last used ARV medications, if he/she is not currently using ARV.

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV					
Antiretroviral use?	Yes	No	Ref	Unk	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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:


## COMMENTS

- Use this section for any other pertinent information such as:

Has **spouse/partner** been tested or reported?

Has patient been **referred** to care coordination? If so, coordinator's name, location and phone number.

Is patient **from another state/country**? If so, were they diagnosed there?

Are there any reported symptoms, such as previous pneumonia, cancer, etc.?

If patient has **children**, have they been tested? If positive, have they been reported?

Expected date of release from jail or prison.

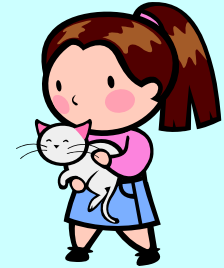
List any other miscellaneous information you feel may be useful.

# XIV. State Use Only

XV. STATE USE ONLY		Census Tract _____	
<p>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.</p> <p>NIR: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p><b>Current Status:</b> <input type="checkbox"/></p> <p>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)*</p> <p>*Enter month/year resolved ____/____</p>	
<p><input type="checkbox"/> Physician Current</p> <p><input type="checkbox"/> Send first reporter packet</p> <p><input type="checkbox"/> Address Current</p> <p><input type="checkbox"/> CLOSED admin.</p> <p><input type="checkbox"/> Sent to DIS Date _____</p> <p><input type="checkbox"/> RETURN TO SURVEILLANCE COORDINATOR</p>		<p><b>Current Status:</b> <input type="checkbox"/></p> <p>1 = 1-2 calls/letters                  2 = 2-4 calls                  3 = 5-10 calls                  4 = Investigated – to DIS (See NIR section)                  5 = Other: _____</p>	
		<p><b>Casework needed to complete report:</b> <input type="checkbox"/></p> <p>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</p>	
		<p>Surveillance Coordinator initials _____</p> <p>Follow-up date _____</p> <p>Follow-up plan _____</p>	

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

**If you are aware of an HIV-positive child under 13 years of age and/or a woman with HIV that just delivered, contact your surveillance department for assistance in completing the appropriate forms.**





**NOTE:** Additional case report forms and other reporting information can be obtained from the ISDH Web site at:

[www.statehealth.in.gov/programs/hivstd/index.htm](http://www.statehealth.in.gov/programs/hivstd/index.htm)

Then, click on **Confidential Case Report Forms**  
and then the **Adult Case Report Form**; print.

Mailing labels can also be obtained by calling (800) 376-2501.

## Surveillance Contacts

<i>Lake County</i>	-	(219) 755-3030
<i>Marion County</i>	-	(317) 221-2132
<i>All other counties, call ISDH Surveillance toll free (800) 376-2501</i>		