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| **Massachusetts Department of Public Health** | State No. |
| **Bureau of Infectious Disease and Laboratory Sciences** | MAVEN ID:  |
| **Office of Integrated Surveillance and Informatics Services** |  |
| 305 South Street, Jamaica Plain, MA 02130 |  |
| *Phone****: 617-983-6801*** | *Confidential Fax****: 617-983-6813*** |  |
| **HIV/AIDS**CONFIDENTIAL CASE REPORT |
| **DEMOGRAPHIC INFORMATION** |
| Last Name: | First Name: | MI: |
| Current Address: | Apt. # | City: |
| State: | Zip: | Contact Phone: ( )  | Full SSN: \_\_ \_\_ \_\_-\_\_ \_\_- \_\_ \_\_ \_\_ \_\_ |
| Residence Type: **□** Permanent **□** Correctional **□** Homeless | □ Deceased: Date of Death: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| Date of birth: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | Sex at birth: **□**Female **□**Male | Country of Birth: |
| Current gender identity: **□** Female **□** Male **□** TransgenderMale to Female **□** Transgender Female to Male **□** Non-binary  |
| Race (check all that apply): □ American Indian/Alaskan Native □ Native Hawaiian/Pacific-Islander □ Asian □ White □ Black/African American □ Unknown □ Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hispanic/Latino: **□**Yes **□**No **□**Unknown | Expanded ethnicity: □ Cape Verdean □ Dominican □ Puerto Rican □ Brazilian □ Haitian □ Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **LABORATORY DATA**(*Please attach all relevant labs and/or EMR notes regarding this case)* |
| **HIV ANTIBODY/ANTIGEN TESTS AT DIAGNOSIS** | **HIV DETECTION TEST** |
| (Record date of earliest test ) | Date: | (Record date of earliest test) |
| HIV-1/2 EIA | □Pos □Neg | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | **Viral load test:** |
| HIV-1/2 Ag/Ab | □Pos □Neg □Ind | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | Result: \_\_\_\_\_\_\_\_\_\_RNA copies/ml \_\_\_\_ log copies |
| HIV-1 WB | □Pos □Neg □Ind | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ |
| HIV-2 WB | □Pos □Neg □Ind | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |  |
| HIV-1/2 differentiating test (select all that apply): | **Other detection test (specify test type):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ HIV-1 Positive □ HIV-2 Positive |  |
| □ Negative □ Indeterminate □ Undifferentiated (both) | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | Result: □ Positive □ Negative □ Indeterminate |
| Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ |
| **IMMUNOLOGIC LAB TESTS** | **OTHER LAB INFORMATION** |
| **At or closest to current diagnostic status:** | **Last documented negative HIV test:** |
| CD4 Count \_\_\_, \_\_\_ \_\_\_\_ \_\_\_cells/µl | CD4 Percent \_\_\_ \_\_\_ % | Specify type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ | Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ |
|  | **If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?** |
| **If ever <200 cells/µl or <14%:** |
| CD4 Count \_\_\_, \_\_\_ \_\_\_\_ \_\_\_cells/µl | CD4 Percent \_\_\_ \_\_\_ % | □ Yes □ No □ Unknown |
| Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ | Date: \_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ |
| **Diagnostic Status:** □ HIV Infection (Not AIDS) □ AIDS  |
| Residence at Diagnosis: | City: | State/Country: | Zip: |
| Facility of Diagnosis:  | City:  | State/Country:  | Zip: |
| Type of Facility: **□** Hospital  **□** Correctional Facility **□** Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **CLINICAL INFORMATION** |
| Treating Provider Name: | Provider phone: ( )\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Treating Facility Name: | Patient MRN #: |
| Was there an AIDS defining condition or opportunistic infection? **□**Yes **□**No **□**Unknown |
| Please specify: | Date of condition: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| Is this patient currently pregnant? | □ Yes □No □Unk | Has this patient delivered live-born infants? | □ Yes □No □Unk |
| Date(s) of birth: | State(s) of birth: |
| Was the patient symptomatic? □ Yes □No □Unk |
| Were partners notified? □ Yes □ No □Unk  | If yes, by whom? □ Patient □ Health Department □ Clinic staff □ Other\_\_\_\_\_\_\_ |
| *To request partner notification services, please contact* **(617) 983-6940** |
| **RISK HISTORY** *(Please respond to all questions)**See Supplement for Pediatric Risk* |
| □Yes □No □Unknown | Sex with male? |
| □Yes □No □Unknown | Sex with female? |
| □Yes □No □Unknown | Injection drug use? |
| □Yes □No □Unknown | Heterosexual sex with injection/intravenous drug user? |
| □Yes □No □Unknown | Heterosexual sex with bisexual male? |
| □Yes □No □Unknown | Heterosexual sex with person with hemophilia/coagulation disorder? |
| □Yes □No □Unknown | Heterosexual sex with transfusion recipient with documented HIV infection? |
| □Yes □No □Unknown | Heterosexual sex with transplant recipient with documented HIV infection? |
| □Yes □No □Unknown | Heterosexual sex with person with AIDS or documented HIV infection? |
| □Yes □No □Unknown | Received clotting factor for hemophilia/coagulation disorder? |
| □Yes □No □Unknown | Received transfusion of blood/blood components (other than clotting factor)? |
| □Yes □No □Unknown | Received transplant of tissue/organs or artificial insemination? |
| □Yes □No □Unknown | Worked in health-care or clinical laboratory setting? Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **HIV ANTIRETROVIRAL(ARV) USE AND TESTING HISTORY** |
| Main source of information (select one) □ Patient Interview □ Medical Record Review □ Provider Report |
| Date patient reported information: : \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | Ever taken ARVs? □ Yes □ No □ Unknown |
| Reason for ARV use (select all that apply): | Date began: | Date of last use: |
| □ HIV Tx  | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| □ PrEP  | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| □ PEP | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| □ PMTCT  | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| □ HBV Tx  | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| □ Other  | ARV medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| Ever had previous positive HIV test? □Yes □No □Unk Date of first positive test: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| Location of first positive test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ever had negative HIV test? | □Yes □No □Unk | Date of last negative HIV test: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| *(if date is from a lab test with test type, enter in lab data section)* |
| Number of negative HIV tests within 24 months before first positive test: | # \_\_\_\_\_\_\_\_ □Unknown |
| **ADMINISTRATIVE INFORMATION** |
| Comments: |
| Name of person completing form: |  | Date completed: | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ |
| Facility name: |  | Phone: | ( \_\_\_\_ )\_\_\_\_\_-\_\_\_\_\_\_\_ |
| *Please send completed form by CONFIDENTIAL FAX to* ***617-983-6813*** |