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| **Massachusetts Department of Public Health** | | | | | | | | State No. | | | |
| **Bureau of Infectious Disease and Laboratory** | | | | | | | | MAVEN ID: | | | |
| **Division of Surveillance, Analytics, and Informatics** | | | | | | | | |  | | |
| 305 South Street, Jamaica Plain, MA 02130 | | | | | | | | |  | | |
| *Phone****: 617-983-6801*** | | *Confidential Fax****: 617-887-8789*** | | | | | | |  | | |
| **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* ***617-887-8789*** | | | | | | | | | | | |