Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory
Division of Surveillance, Analytics and Informatics
305 South Street, Jamaica Plain, MA 02130
*Phone: **617-983-6801*** *Confidential Fax: **617-887-8789***

State No.
MAVEN ID:

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 □ Transgender Male 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 _____

LABORATORY DATA

(*Please attach all relevant labs and/or EMR notes regarding this case)*

HIV ANTIBODY/ANTIGEN TESTS AT DIAGNOSIS

(Record date of earliest test) Date:

HIV-1/2 EIA	□Pos □Neg	__ __/__ __/__ __ __ __
HIV-1/2 Ag/Ab	□Pos □Neg □Ind	__ __/__ __/__ __ __ __
HIV-1 WB	□Pos □Neg □Ind	__ __/__ __/__ __ __ __
HIV-2 WB	□Pos □Neg □Ind	__ __/__ __/__ __ __ __

HIV-1/2 differentiating test (select all that apply):
□ HIV-1 Positive □ HIV-2 Positive
□ Negative □ Indeterminate __ __/__ __/__ __ __ __
□ Undifferentiated (both)

HIV DETECTION TEST

(Record date of earliest test)

Viral load test:

Result: _____RNA copies/ml ____ log copies

Date: ____ ____/____ ____/____ ____ ____ ____

Other detection test (specify test type):

_____

Result: □ Positive □ Negative □ Indeterminate

Date: ____ ____/____ ____/____ ____ ____ ____

IMMUNOLOGIC LAB TESTS

At or closest to current diagnostic status:

CD4 Count ___, ___ ____ ___cells/µl CD4 Percent ___ ___ %

Date: ____ ____/____ ____/____ ____ ____ ____

If ever <200 cells/µl or <14%:

CD4 Count ___, ___ ____ ___cells/µl | CD4 Percent ___ ___ %

Date: ____ ____/____ ____/____ ____ ____ ____

OTHER LAB INFORMATION

Last documented negative HIV test:

Specify type:_____

Date: ____ ____/____ ____/____ ____ ____ ____

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?

□ Yes □ No □ Unknown

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_____			

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: _____

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***	