**Instructions for Completing the Adult HIV/AIDS Case Report Form**

**The Commonwealth of Massachusetts reporting regulations (105 CMR 300) identify HIV and AIDS as reportable diseases and mandate that healthcare providers licensed by the Commonwealth and facilities licensed by the Department (hospitals, clinics or nursing homes) report HIV and AIDS cases directly to the Bureau of Infectious Disease and Laboratory Sciences (BIDLS) at the Massachusetts Department of Public Health (MDPH). Because persons with HIV infection may receive treatment from different health care providers, the primary medical care provider and/or the facility where care is provided are considered the principal source of HIV case reports. Facilities with large HIV caseloads should develop a coordinated reporting plan and designate an individual responsible for reporting.**

**This document provides detailed instructions and guidance for completing the form. Please fill in the form as completely as possible**.

**DEMOGRAPHIC INFORMATION**This information must be filled in as it appears on the medical record.

**Last Name, First Name, MI**: Fill this out completely with patient’s legal name. If the patient has an alias or a maiden name, married name, birth name, or nickname write the type of alias and the full alias in the comments field.

**Current Address & Residence Type**: Indicate the patient’s complete current address. This address may be different from the residence at diagnosis. Indicate the type of address at which the client is currently residing. ‘Permanent’ indicates residential address and ‘Correctional’ indicates a prison or jail. If the choices do not adequately describe the patient’s current living situation, describe the current living situation in the comments section on the back of the form.

**Contact Phone**: Complete with patient’s phone number.

**Social Security Number**: Indicate the entire social security number if it is available. If only the last four digits of the social security number are known, please indicate those.

**Gender**

* Sex at Birth: Indicate sex at birth.
* Current Gender Identity: Indicate the patient’s gender identity at the time of report. If you have previously reported a transgender patient using only their sex at birth, we welcome any updates that your facility would like to submit.

**Birth and Death Information**

* Date of Birth: Fill in numbers corresponding to the month, day, and year of birth in the designated fields (Jan= 01, Feb=02, etc. Example: June 8, 1955= 06/08/1955). If the patient has an alias date of birth, indicate that in the comments section.
* Country of Birth: Fill in the text field indicating country of birth.
* Deceased: If the patient is dead, check the deceased box and fill in date.

**Race and Ethnicity**

* Race: Select all races that apply to the patient.
* Hispanic/Latino: Select yes, no, or unknown as appropriate.
* Expanded Ethnicity: Select appropriate ethnicities if applicable or write in ethnicity if not listed.

**LABORATORY DATA**

**Fill in the relevant boxes for all test results available. Please only indicate labs for which you have results.**

**This can include medical records or laboratory results that have been obtained from other sites, but do not include undocumented patient self-reported information in this section. Self-reported information is collected in the HIV ANTIRETROVIRAL (ARV) USE AND TESTING HISTORY section on the 2nd page of the form.**

Throughout this section, the date refers to the date when the specimen was collected or drawn. Enter collection dates in *mm/dd/yyyy* format, using “..” for unknown values.

**HIV ANTIBODY/ANTIGEN TESTS AT DIAGNOSIS**

Indicate the first antibody test type, result, and date.

* HIV-1/2 EIA = 2nd – 3rd generation EIA/ELISA immunoassay
* HIV-1/2 Ag/Ab = 4th generation immunoassay that detects both HIV-1 and HIV-2 antibodies and HIV-1 antigen. This is the recommended initial test in the HIV testing algorithm.
* HIV-1 WB = detects HIV-1 antibodies
* HIV-2 WB = detects HIV-2 antibodies
* HIV-1/2 differentiating test = Type-differentiating assay that is able to distinguish between HIV-1 and HIV-2 antibodies (e.g., Geenius). If both HIV-1 and HIV-2 were detected, check both HIV-1 Positive and HIV-2 Positive. This is the recommended second test in the HIV testing algorithm,

**HIV DETECTION TEST**

Indicate the earliest HIV-1 RNA viral load test and complete the copies/mL and/or log copies result for the test. Viral load tests for HIV-1 RNA include RT-PCR, bDNA, and NASBA.

Other detection testscan include, but are not limited to: P24 antigen, HIV-1 culture, HIV-2 RNA viral load test, HIV-2 culture, and the NAAT or Qualitative RNA viral load tests.

**IMMUNOLOGIC LAB TESTS**

Indicate CD4 laboratory results at or closest to current diagnostic status (most recent).

For AIDS reports, record the CD4 count and percent closest to the date of AIDS diagnosis. This AIDS diagnosis date is typically the date on which an AIDS-defining illness is diagnosed or the specimen collection date of a CD4 count that is < 200 cells/μL (or a CD4 percent that is <14% with no corresponding count).

**OTHER LAB INFORMATION**

**Last Documented Negative HIV Test**

Please only indicate a result and a date if a documented laboratory result is available. Client or patient self-reported negative tests should be completed in the HIV ANTIRETROVIRAL (ARV) USE AND TESTING HISTORY section.

**HIV Diagnosis by Physician**

If laboratory evidence of an HIV test is not available in the medical record and the patient was diagnosed by a physician in lieu of documented laboratory tests, check “YES”. Otherwise, check “NO” or “UNKNOWN”. If “YES”, provide date of diagnosis by physician. For example if Dr. X wrote on January 1, 2018, “Patient reports that they were first diagnosed in 1998”, you would indicate the physician diagnosis date in this section as ‘../../1998’.

**DIAGNOSTIC STATUS**

Mark box to indicate whether patient has HIV or AIDS.

**Residence at diagnosis**

This refers to the location where the person was living at the time they were diagnosed with HIV or AIDS. If the patient is homeless, indicate the city in which the patient resides at the time of diagnosis. The residence at diagnosis may be different than the residence listed under Demographic Information. If you are reporting an HIV infection, report the residence at HIV diagnosis. If you are reporting an AIDS case, report the residence at AIDS diagnosis.

**Facility of Diagnosis**

This refers to the facility where the patient was diagnosed with HIV or AIDS. If you are reporting an HIV infection, indicate the facility where the patient was diagnosed with HIV. If you are reporting an AIDS case, indicate the facility where the patient was diagnosed with AIDS.

**Type of Facility**

Indicate the type of facility where the diagnosis was made (Hospital, Correctional, Other).

**CLINICAL INFORMATION**

**Treating Provider Name**

Indicate the current or most recent treating provider.

**Provider Phone**

Phone number of current or most recent treating provider.

**Treating Facility Name**

Indicate the current or most recent facility of treatment.

**Patient MRN #**

Indicate patient Medical Record Number as noted in patient records.

**AIDS Defining Condition or OI**

The most commonly reported AIDS-defining conditions are listed at the end of this document for reference. Indicate if the patient has had any AIDS-defining conditions or opportunistic infections since HIV diagnosis, specify the condition, and note the date of the condition.

**Reproductive Information**

* Indicate if patient is pregnant.
* Indicate if patient has delivered live-born infants. If “YES”, please also indicate:
	+ Date(s) of birth of child(ren)
	+ State(s) of birth of child(ren) (Include country if birth was outside US)

**Symptoms**

Indicate if the patient was symptomatic. This could include fever, malaise/fatigue, myalgia, pharyngitis, rash, and/or lymphadenopathy. Generally, two or more symptoms such as these are present.

**RISK HISTORY**

Check off either “Yes”, “No”, or “Unknown” for **all** items.

**HIV ANTIRETROVIRAL (ARV) USE AND TESTING HISTORY**

Using patient self-reported data is okay in this section.

Note the main source of information and date of reported information.

* Has the patient ever taken ARV’s? Check off reason for patient’s ARV use and indicate name of medication.
* Did the patient ever have a previous positive HIV test? Check appropriate answer. If yes, indicate date and location in line provided.
* Did the patient ever have a negative HIV test? Check appropriate answer. If yes, indicate date and location in line provided.

**Once the form is completed, please fax to BIDLS, MDPH at 617-983-6813 or mail it to the Office of Integrated Surveillance and Informatics Services, Room 564, Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130. *Make sure that the envelope is marked "Confidential“.***

**If you have questions about the HIV/AIDS Confidential Case Report form call 617-983-6560.**

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| **AIDS-Defining Conditions** |
| Candidiasis, bronchi, trachea or lungs |
| Candidiasis, esophageal |
| Carcinoma, invasive cervical |
| Coccidiodomycosis, disseminated or extrapulmonary |
| Cryptococcosis, extrapulmonary |
| Cryptosporidiosis, chronic intestinal (>1 mo. duration) |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) |
| Cytomegalovirus retinitis (with loss of vision) |
| HIV encephalopathy |
| Herpes simplex: chronic ulcers (> 1 mo. duration), bronchitis, pneumonitis or esophagitis |
| Histoplasmosis, disseminated or extrapulmonary |
| Isosporiasis, chronic intestinal (> 1 mo. duration) |
| Kaposi’s sarcoma |
| Lymphoid interstitial pneumonia and/or pulmonary lymphoid |
| Lymphoma, Burkitt’s (or equivalent) |
| Lymphoma, immunoblastic (or equivalent) |
| Lymphoma, primary in brain |
| *M. tuberculosis*, pulmonary |
| *M. tuberculosis*, disseminated or extrapulmonary |
| *Mycobacterium avium* complex or *M.kansasii*, disseminated or extrapulmonary |
| *Mycobacterium*, of other species/unidentified species, disseminated or Extrapulmonary |
| *Pneumocystis carinii* pneumonia |
| Pneumonia, recurrent, in 12 mo. Period |
| Progressive multifocal leukoencephalopathy |
| Salmonella septicemia, recurrent |
| Toxoplasmosis of brain |
| Wasting syndrome due to HIV |