PATIENT INFORMATION

Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #:
(   )   -

Social Security #:
          --   --

Email:

Current Street Address:

City:

Zip Code:

☐ Alive
☐ Dead

Birthdate (mm/dd/yyyy)
____ / ____ / ____

Death date (mm/dd/yyyy)
____ / ____ / ____

State of death:

Sex at birth:
☐ Male
☐ Female

Current gender identity:
☐ Male   ☐ Male to Female
☐ Female ☐ Female to Male

Ethnicity:
☐ Hispanic
☐ Not Hispanic

Marital Status:
☐ Married   ☐ Divorced
☐ Widowed   ☐ Never
☐ Unknown   married

Race (check all that apply):
☐ White   ☐ Native Hawaiian/Pacific Islander
☐ Black   ☐ American Indian/Alaska Native
☐ Asian

Country of birth: ☐ U.S.   ☐ Other: _____

If other, date of entry into U.S.: ____ / ____ / ____

Language: ☐ English   ☐ Other:_____

Was the patient dx in another state?   ☐ Yes   ☐ No
If yes, specify state: _____

Residence at time of diagnosis if different than current address:

Medical Record # / Patient Code:

Name & City of facility of diagnosis:

☐ Outpatient diagnosis[2]   ☐ Inpatient diagnosis[2]

PROVIDER INFORMATION

Physician: Phone:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977[3]

Check all that apply:	Yes	No	Unk
Sex with male……………………………………	☐	☐	☐
Sex with female…………………………………	☐	☐	☐
Injection drug use……………………………..	☐	☐	☐
Received clotting factors for hemophilia………….	☐	☐	☐
Transfusion, Transplant, or Insemination………….	☐	☐	☐
Heterosexual relations with:			
Injection drug user…………………………..	☐	☐	☐
Bisexual man…………………………………	☐	☐	☐
Person with hemophilia………………………..	☐	☐	☐
PWA/HIV transfusion or transplant……………	☐	☐	☐
PWA/HIV risk not specified………………………	☐	☐	☐

HEALTH DEPARTMENT USE ONLY

☐ HIV   ☐ AIDS   Stateno:_____

Date: ____ / ____ / ____   Source: _____

☐ New case   ☐ Progression   ☐ Update, no status change

HIV DIAGNOSTIC TESTS

Type of Test — *At least 2 antibody tests must be indicated for an HIV diagnosis* — IA = Immunoassay	Collection date	Rapid test	Positive/ Reactive	Indeterminate	Negative / Non-Reactive
Last Negative Test (prior to HIV diagnosis)	____ / ____ / ____		▓	▓	
HIV-1/2 Ag/Ab Lab IA (4th Gen)	____ / ____ / ____				
HIV-1/2 EIA IA (2nd or 3rd Gen)	____ / ____ / ____			▓	
HIV1/HIV2 Type Differentiating IA ☐ Multispot ☐ Geenius	____ / ____ / ____	▓	☐ HIV-1 ☐ HIV-2 ☐ Undiff		
HIV-1 Western Blot	____ / ____ / ____	▓			
HIV-1 RNA/DNA Qualitative NAAT	____ / ____ / ____			▓	
OTHER: _____	____ / ____ / ____				

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider?
☐ No
☐ Yes → Date of documentation by care provider: _____ / _____ / _____
☐ Unknown

HIV CARE TESTS[4]

HIV VIRAL LOAD TESTS

	Test Date	Copies/ml
Earliest HIV viral load	____ / ____ / ____	_____
Most recent HIV viral load	____ / ____ / ____	_____

EARLIEST DRUG RESISTANCE TEST

Date: ____ / ____ / ____   ☐ Genotype   ☐ Phenotype

Laboratory:_____

CD4 LEVELS

	Test Date	Count	%
Earliest CD4	____ / ____ / ____	____cells/µl	_____%
Most recent CD4	____ / ____ / ____	____cells/µl	_____%
First CD4 <200 µl	____ / ____ / ____	____cells/µl	_____%

OPPORTUNISTIC INFECTIONS[4,5]

	Diagnosis date		Diagnosis date
☐ Candidiasis, esophageal	____ / ____ / ____	☐ Kaposi's sarcoma	____ / ____ / ____
☐ Cryptococcosis, extrapulmonary	____ / ____ / ____	☐ Pneumocystis carinii pneumonia	____ / ____ / ____
☐ Cytomegalovirus disease (other than in liver, spleen, nodes)	____ / ____ / ____	☐ Wasting syndrome due to HIV	____ / ____ / ____
☐ Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis	____ / ____ / ____	☐ Other: _____	____ / ____ / ____

HIV TESTING AND TREATMENT HISTORY

Date patient reported info: _____/_____/_____

Information from: ☐ Patient interview   ☐ Review of medical record
☐ Provider report   ☐ PEMS   ☐ Other

FIRST POSITIVE HIV TEST	NEGATIVE HIV TESTS
Ever had a previous positive test? ☐ Yes ☐ No ☐ Unknown	Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown
Date of first positive test: _____/_____/_____	Date of last negative test: _____/_____/_____ Number of negative HIV tests in 24 months before first positive test: _____

HISTORY OF HIV-RELATED MEDICATIONS   (check all that apply)

Ever taken any antiretroviral medications (ARVs)?   ☐ Yes   ☐ No   ☐ Unknown

Reason	Name(s) of medication(s)	Date began	Date of last use
☐ HIV treatment	_____	___/___/___	___/___/___
☐ PrEP	_____	___/___/___	___/___/___
☐ PEP	_____	___/___/___	___/___/___
☐ Pregnancy	_____	___/___/___	___/___/___
☐ Hep B treatment	_____	___/___/___	___/___/___
☐ PCP Prophylaxis	_____	___/___/___	___/___/___
☐ Other	_____	___/___/___	___/___/___

DRUG USE

Methamphetamine use?   ☐ Yes → ☐ Injection   ☐ Non-injection, specify: _____   ☐ Unk
☐ No
☐ Unknown

TREATMENT/SERVICES REFERRALS

	Yes	No	Unk	N/A
Has this patient been informed of his/her HIV infection?	☐	☐	☐	
This patient is receiving/has been referred for:				
▪ HIV related medical service	☐	☐	☐	
▪ HIV Social Service Case Management	☐	☐	☐	
▪ Substance abuse treatment services	☐	☐	☐	☐

FOR WOMEN

Is patient currently pregnant?   ☐ Yes → Expected delivery date: ____/____/_____
☐ No
☐ Unknown

FOR HEALTH DEPARTMENT USE ONLY

Stateno: _____   Date received: _____/_____/_____

Case report completed/verified by: _____

☐ Complete   ☐ Incomplete   ☐ OOS

RVCT Number: _____

FOOTNOTES

[1] Patient identifier information is not sent to CDC.
[2] Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc. Inpatient dx: diagnosed during a hospital admission of at least one night.
[3] After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
[4] If case progresses to AIDS, please notify health department.
[5] Opportunistic illnesses include: Candidiasis, bronchi, trachea, or lungs; Candidiasis, esophageal; Cervical cancer, invasive; Coccidioidomycosis, disseminated or extrapulmonary; Cryptococcosis, extrapulmonary; Cryptosporidiosis, chronic intestinal; Cytomegalovirus disease (other than liver, spleen, or nodes); Cytomegalovirus retinitis (with loss of vision); HIV encephalopathy; Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis; Histoplasmosis, diss. or extrapulmonary; Isosporiasis, chronic intestinal; Kaposi's sarcoma; Lymphoma, Burkitt's (or equivalent); Lymphoma, immunoblastic (or equivalent); Lymphoma, primary in brain; Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary; M. tuberculosis, pulmonary; M. tuberculosis, diss. or extrapulmonary; Mycobacterium of other or unidentified species, diss. or extrapulmonary; Pneumocystis pneumonia; Pneumonia, recurrent; Progressive multifocal leukoencephalopathy; Salmonella septicemia, recurrent; Toxoplasmosis of brain; Wasting syndrome due to HIV

WASHINGTON STATE REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

ASSURANCES OF CONFIDENTIALITY AND EXCHANGE OF MEDICAL INFORMATION

▪ Several Washington State laws pertain to HIV/AIDS reporting requirements. These include: Maintain individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protect patient identifying information, meet published standards for security and confidentiality if retaining names of those with asymptomatic HIV, (WAC 246-101-230,520,635); investigate potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclose HIV/AIDS identifying information (WAC 246-101-120,230,520,635 and RCW 70.24.105).
▪ Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).
▪ Anyone who violates Washington State confidentiality laws may be fined a maximum of $10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

FOR PARTNER NOTIFICATION INFORMATION

▪ Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).
▪ For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call HIV/AIDS Prevention & Education Services, Public Health Seattle & King County, at (206) 263-2410.

Comments: