Florida Adult HIV/AIDS Confidential Case Report

(Patients ≥ 13 years of age at time of diagnosis)

I. HEALTH DEPT USE ONLY

Date Received at Health Department	Did this report initiate a new case investigation?	State Number
___ ___/ ___ ___/ ___ ___ ___ ___	❑ Yes ❑ No ❑ Unknown	

Document Source	Surveillance Method	Report Medium
A_____-_____-_____-____	A F P R	❑ Field Visit ❑ Mailed ❑ Faxed ❑ Phone ❑ Electronic Transfer ❑ CD/Disk

Report Status New Update	Reporting Health Department- City

II. PATIENT IDENTIFIER INFORMATION-*data not transmitted to CDC*

Patient Name Last Name	First Name	Middle Name	Social Security Number

Address ❑ Residential ❑ Bad Address ❑ Correctional Facility ❑ Foster Home ❑ Homeless ❑ Postal ❑ Shelter ❑ Temporary	Current Street Address

City	State	Zip Code	County	Phone ( )

City/County Patient Number

III. DEMOGRAPHIC INFORMATION-*complete **ALL** fields*

Diagnostic Status ❑ HIV ❑ AIDS	Sex assigned at Birth ❑ Male ❑ Female	Date of Birth __ __/__ __/__ __ __ __
Country of Birth ❑ US ❑ Other (specify):		Status ❑Alive ❑Dead
Date of Death ___ ___/___ ___/___ ___ ___ ___	State/Territory of Death _____	

Current Gender Identity ❑ Male ❑ Female ❑Transgender Male-to-Female (MTF) ❑ Transgender Female-to-Male (FTM) ❑ Unknown
❑ Additional gender identity (specify) _____

Ethnicity (select one): ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown

Race: (select all that apply) ❑ Black/AA ❑ Asian ❑ Native American or Alaskan ❑ White ❑ Hawaiian/PI ❑ Unknown

Residence at Diagnosis: ❑ Same as Current Street Address:
City: County: State/Country: Zip:

IV. FACILITY OF DIAGNOSIS

Facility Name:

Address:

City:

State/Country: Zip:

Facility Type (check one)
❑ Physician, HMO ❑ Hospital, Inpatient ❑ Other

Facility Code:

Facility Setting (check one)
❑ Public ❑ Private ❑ Federal ❑ Other

Provider Name (Last, First, MI)

Provider Ph. No. ( )

Med. Rec. No:

Person Completing Form (Last, First, MI)

Phone No. ( )

Date form completed _____/_____/_____

V. PATIENT HISTORY- *complete **ALL** fields*

Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (Respond to **ALL** Categories)

	Yes	No	Unk
Sex with male……	❑	❑	❑
Sex with female……	❑	❑	❑
Injected non-prescription drugs……	❑	❑	❑
Received clotting factor for hemophilia/coagulation disorder……	❑	❑	❑
Specify disorder: ☐ Factor VIII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other (specify):			
HETEROSEXUAL relations with any of the following:			
Intravenous/Injection Drug User……	❑	❑	❑
Bisexual male (**applies to females only**)……	❑	❑	❑
Person with hemophilia/coagulation disorder……	❑	❑	❑
Transfusion recipient with documented HIV infection……	❑	❑	❑
Transplant recipient with documented HIV infection……	❑	❑	❑
Person with AIDS or documented HIV infection, risk unspecified……..	❑	❑	❑
Received transfusion of blood/blood components (other than clotting factor) First Date:____/____/____ Last Date:____/____/____	❑	❑	❑
Received organ transplant, tissue or artificial insemination……	❑	❑	❑
Worked in healthcare or clinical laboratory……..	❑	❑	❑
(specify occupation):_____			
Other documented risk	❑	❑	❑

VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test-mm/dd/yyyy)			**HIV Detection Tests**: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 NAT		
HIV-1/2 EIA			HIV-1 Qual PCR RNA		
HIV -1/2 Ag/Ab			HIV-1 P24 Antigen		
HIV-1/2 Differentiating			HIV-1 Qual PCR DNA		
(e.g., Multispot)			Other		
HIV-1 Western Blot/IFA			Other		
Other			Other		
Other			Other		

Viral Load Test: (**most recent** test- mm/dd/yyyy)			**Immunologic Lab Test:** (test date-mm/dd/yyyy)	
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date
HIV-1 NASBA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RT-PCR			**First<200 or <14% of total lymphocytes**	
HIV-1 bDNA			CD4 Count:_____ cells/ul (_____%)	
Other				

Physician Diagnosis:

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ❑ Yes ❑ No ❑ Unknown

If yes, enter date of diagnosis (mm/dd/yyyy) _____

VII. CLINICAL STATUS

Clinical Record Reviewed? ❑ **Yes** ❑ **No**	**Initial Dx Date mm/dd/yyyy**	**Def.**	**Pres.**		**Initial DxDate mm/dd/yyyy**	**Def.**	**Pres.**
Candidiasis, bronchi, trachea, or lungs	____/____/_____	❑		Lymphoma, Burkitt's (or equivalent term)	____/____/_____	❑	
Candidiasis, esophageal	____/____/_____	❑	❑	Lymphoma, immunoblastic (or equivalent terms)	____/____/_____	❑	
Carcinoma, invasive cervical	____/____/_____	❑		Lymphoma, primary in brain	____/____/_____	❑	
Coccidioidomycosis, disseminated or extrapulmonary	____/____/_____	❑		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	____/____/_____	❑	❑
Cryptococcosis, extrapulmonary	____/____/_____	❑		M. tuberculosis, pulmonary *	____/____/_____	❑	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	____/____/_____	❑		M. tuberculosis, disseminated, or extrapulmonary *	____/____/_____	❑	❑
Cytomegalovirus disease (other than in liver, spleen, or nodes)	____/____/_____	❑		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	____/____/_____	❑	❑
Cytomegalovirus retinitis (loss of vision)	____/____/_____	❑	❑	Pneumocystis carinii pneumonia	____/____/_____	❑	❑
HIV encephalopathy	____/____/_____	❑		Pneumonia, recurrent, in 12 mo. period	____/____/_____	❑	❑
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	____/____/_____	❑		Progressive multifocal leukoencephalopathy	____/____/_____	❑	
Histoplasmosis, disseminated, or extrapulmonary	____/____/_____	❑		Salmonella septicemia, recurrent	____/____/_____	❑	
Isosporiasis, chronic intestinal (>1 mo. duration)	____/____/_____	❑		Toxoplasmosis of brain	____/____/_____	❑	❑
Kaposi's sarcoma	____/____/_____	❑	❑	Wasting syndrome due to HIV	____/____/_____	❑	

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT Case Number_____

VIII. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection?	❑ Yes ❑ No ❑ Unknown
This patient's partners will be notified about their HIV exposure and counseled by: ❑ 1-Health Dept ❑ 2-Physician/Provider ❑ 3-Patient ❑ 9-Unknown	
WOMEN ONLY	
Is patient receiving or been referred for obstetrical or gynecological services?	❑ Yes ❑ No ❑ Unknown
Is patient currently pregnant?	❑ Yes ❑ No ❑ Unknown
If YES, EDC (due date) / /	
Has patient delivered a live-born infant?	❑ Yes ❑ No ❑ Unknown

CHILD OF PATIENT (record most recent birth in these boxes; record additional or multiple births in the Comments section)

Hospital:	City:	State:	Zip:
Child's Name (Last, First, MI)	Child's State No:	Date of Birth __ __/__ __/__ __ __ __	

IX. LOCAL FIELDS

PRISM # **NIR STATUS: NIR_____OP_____ NIR OP DATE _____**

DOC # **NIR_CL_____ NIR CL DATE:_____**

Link with eHARS stateno(s): **NIR_RE_____ NIR RE DATE:_____**

OTHER RISKS: A___ B/C____ D____ F____ M____ V____ J____ **INITIALS (3)_____ SOURCE CODE A_____**

HEPATITIS: A____ B____ C____ Other____ Unknown____

X. COMMENTS:

XI. INCIDENCE and RESISTANCE

HIV TESTING AND ANTIRETROVIRAL USE HISTORY (record all dates as MM/DD/YYYY)

Main source of testing and treatment history information (select one)

❑ Patient Interview ❑ Medical Record Review ❑ Provider Report ❑ Other _____

Date patient reported information

__ __ / __ __ / __ __ __ __

Ever had a previous positive HIV test? ❑ Yes ❑ No ❑ Refused ❑ Unknown

If **YES**, date of First Positive HV test __ __/__ __/__ __ __ __

If **YES,** in what **STATE** was the **First Positive** HIV test performed? _____

Ever had a negative HIV test? ❑ Yes ❑ No ❑ Unknown ❑ Refused If **YES,** date of Last Negative test __ __/ __ __/__ __ __ __

Number of ***negative*** HIV tests within 24 months before first positive #_____ ❑ Refused ❑ Unknown

If **YES**, in what **STATE** was the **Last Negative** HIV test performed? _____

Ever taken any antiretrovirals (ARVs)? ❑ Yes ❑ No ❑ Unknown ❑ Refused

First date of ARV/HIV medication ___ ___/___ ___/___ ___ ___ ___

Last date of ARV/HIV medication ___ ___/___ ___/ ___ ___ ___ ___ ❑ Patient is currently taking any ARV

Code of ARV medication(s) _____ _____ _____ _____

General Guidance on Section XI – HIV/AIDS Incidence

Yes	evidence that the event occurred
No	evidence that the event did NOT occur
Unknown	1) evidence that patient said, "Don't know" 2) provider documented "Unknown" or 3) insufficient evidence
Refused	Patient refused, provider documented "Refused," or the facility did not allow for medical record review
Blank	Patient or provider was not asked or source was not investigated

For all dates, only enter information that you have evidence of. For example, if only month & year are known enter 05/__/2000 or if only the year is known enter __/__/2000.

Patient Information
Please select the source of Testing and Treatment History (TTH) information by checking the appropriate source box. If you use a source not listed, please specify that source on the "Other" line provided. **Only one source may be used per form.** Record the Date patient reported information as follows:

- For Medical Record Review: Date when most recent TTH data provided. Do NOT use the date of review unless no other date is available.
- For Provider Report: Date when TTH information was obtained from patient. If date is unknown, enter date when report was received at health department.
- For Other: Use the date the TTH information was originally collected.

Previous Positive Testing History
All of the questions in this section reference the patient's first positive HIV test ever. **Only complete this section when there is evidence regarding a positive test before the one which initiated the case report.** List the month (mm), day (dd), and year (yyyy) of the patient's first positive test. If date is unknown, leave date field blank. Indicate the state where the first positive HIV test was performed.

Previous Negative Testing History
Indicate whether the patient has ever had a negative HIV test prior to receiving their first positive result. List the month (mm), day (dd), and year (yyyy) of the patient's last negative test. If date is unknown, leave date field blank. Indicate the total number of negative tests the patient had during the twenty-four months prior to receiving their first positive result. Indicate the state where the last negative HIV test was performed.

XIV. Antiretroviral Medications
Indicate whether the patient has ever taken any HIV or antiretroviral medications (ARVs). If yes, indicate date the patient first began taking HIV or ARV medications. List the date the patient stopped taking ARV medications. List the names of the medications taken using the abbreviation list below. Check the box if the client is currently taking HIV or ARV meds.

Medicine Codes

22= Agenerase (amprenavir)
30= Aptivus (tipranavir, TPV)
32= Atripla (efavirenz/ emtricitabine/ tenofovir DF)
24= Combivir (lamivudine/ zidovudine)
06= Crixivan (indinavir sulfate)
11= Emtriva (emtricitabine, FTC)
03= Epivir (lamivudine, 3TC)
28= Epzicom (3TC/ABC)
25= Fortovase (saquinavir)
10= Fuzeon (enfuvirtide, T-20)
19= Hepsera (adefovir)
02= Hivid (zalcitabine, ddC)
23= Hydroxyurea
18= Invirase (saquinavir mesylate)
34= Intelence (etravirine)
36= Isentress (raltegravir)
16= Kaletra (lopinavir/ ritonavir)
31= Lexiva (fosamprenavir, 908)
07= Norvir (ritonavir)
33= Prezista (darunavir, DRV)
09= Rescriptor (delavirdine mesylate)
26= Retrovir (zidovudine, ZDV, AZT)
15= Reyataz (atazanavir sulfate)
08= Saquinavir (Fortavase, Invirase)
35= Selzentry (maraviroc)
21= Sustiva (efavirenz)
13= Trizivir (abacavir sulfate/ lamivudine/ zidovudine)
27= Truvada (FTC/TDF)
01= Videx (didanosine, ddl)
14= Videx EC (didanosine, l)
17= Viracept (nelfinavir mesylate)
05= Viramune (nevirapine)
12= Viread (tenofovir)
04= Zerit (stavudine, d4T)
20= Ziagen (abacavir sulfate)
88= Other
99= Unspecified