ADULT HIV CONFIDENTIAL CASE REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
DISEASE CONTROL
SFN 61112 (8-2016)

Required Patient Demographic Information

First Name	*Last Name*		*Date of Birth*	
Street Address	*City*	*State*	*ZIP Code*	*Telephone Number*

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused ☐ Expanded Ethnicity: _____

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused ☐ Expanded Race: _____

Country of Birth ☐ US ☐ Other (please specify): _____ | *Sex at Birth* ☐ Male ☐ Female

Current Gender Identity ☐ Male ☐ Female ☐ Transgender Male to Female (MTF) ☐ Transgender Female to Male (FTM) ☐ Unknown ☐ Additional gender identity (please specify): _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown

Facility Providing Information

Facility Name					
City	*County*		*State*	*ZIP Code*	*Telephone Number*
Facility Type	*Inpatient:* ☐ Hospital ☐ Other: _____	*Outpatient:* ☐ Adult HIV Clinic ☐ Private Physician's Office ☐ Other: _____	*Screening, Diagnostic, Referral Agency:* ☐CTR ☐ STD Clinic ☐ Other: _____	*Other Facility:* ☐ Emergency Room ☐ Corrections ☐ Laboratory ☐ Other: _____	
Date Form Completed		*Person Completing Form*			

Diagnosis Status at Report: ☐ HIV infection (not AIDS) ☐ AIDS

Residence at Diagnosis

Residence at HIV Diagnosis ☐ Same as current address			*Address Date* _____	
Street Address	*City*	*County*	*State*	*ZIP Code*
Residence at AIDS Diagnosis ☐ Same as residence at HIV diagnosis			*Address Date* _____	
Street Address	*City*	*County*	*State*	*ZIP Code*

Facility of Diagnosis

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ AIDS ☐ Check if SAME as Facility Providing Information

Facility Name				*Date of Diagnosis*	
City	*County*		*State*	*ZIP Code*	*Telephone Number*
Facility Type	*Inpatient:* ☐ Hospital ☐ Other: _____	*Outpatient:* ☐ Adult HIV Clinic ☐ Private Physician's Office ☐ Other: _____	*Screening, Diagnostic, Referral Agency:* ☐CTS ☐ STD Clinic ☐ Other: _____	*Other Facility:* ☐ Emergency Room ☐ Corrections ☐ Laboratory ☐ Other: _____	
Provider Name	*Provider Telephone Number*		*Provider Specialty*		

Patient History

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:			
Sex with male	☐ Yes	☐ No	☐ Unknown
If yes, did they have sex with a male within the last 12 months?	☐ Yes	☐ No	☐ Unknown
Sex with female	☐ Yes	☐ No	☐ Unknown
If yes, did they have sex with a female within the last 12 months?	☐ Yes	☐ No	☐ Unknown
Injected non-prescription drugs	☐ Yes	☐ No	☐ Unknown
If yes, have they shared drug injection equipment such as needles?	☐ Yes	☐ No	☐ Unknown
Sex with an intravenous/injection drug user (IDU)	☐ Yes	☐ No	☐ Unknown
If yes, did they have sex with an IDU within the last 12 months?	☐ Yes	☐ No	☐ Unknown
Type of contact ☐ Homosexual ☐ Heterosexual ☐ Bisexual			
Unprotected sex	☐ Yes	☐ No	☐ Unknown
If yes, did they have unprotected sex within the last 12 months?	☐ Yes	☐ No	☐ Unknown
Received clotting factor for hemophilia/coagulation disorder	☐ Yes	☐ No	☐ Unknown
Specify Clotting Factor	Date Received		
HETEROSEXUAL relations with any of the following:			
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes	☐ No	☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes	☐ No	☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes	☐ No	☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes	☐ No	☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes	☐ No	☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes	☐ No	☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in comments)	☐ Yes	☐ No	☐ Unknown
Date First Received	Date Last Received		
Received transplant of tissue/organs or artificial insemination	☐ Yes	☐ No	☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes	☐ No	☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:			
Other documented risk (please include detail in Comments)	☐ Yes	☐ No	☐ Unknown
Comments:			

Laboratory Data

HIV Antibody Tests (Non-type differentiating)

Test 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer: _____ Collection Date: _____
Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate ☐ Rapid Test (check if rapid)

Test 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer: _____ Collection Date: _____
Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate ☐ Rapid Test (check if rapid)

HIV Immunoassays (Differentiating)

Test: ☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer: _____
Result: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: _____ ☐ Rapid Test (check if rapid)

Test: ☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer: _____
Result: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: _____ ☐ Rapid Test (check if rapid)

Test: ☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab))
Test Brand Name/Manufacturer: _____
Result: *HIV-1 Ag* ☐ Reactive ☐ Nonreactive ☐ Not Reported
HIV- Ab ☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV- Ab
Collection Date:

HIV Detection Tests (Qualitative)

Test: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture
Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Collection Date: _____

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

Test 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Result: ☐ Detectable ☐ Undetectable Copies/mL: _____ Log: _____ Collection Date: _____

Test 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Result: ☐ Detectable ☐ Undetectable Copies/mL: _____ Log: _____ Collection Date: _____

Immunologic Tests (CD4 count and percentage)

At or closest to diagnosis:	*First CD4 result <200* cells/μL or <14%:	*Other CD4 result:*
CD4 count: _____ cells/μL	CD4 count: _____ cells/μL	CD4 count: _____ cells/μL
CD4 percentage: _____%	CD4 percentage: _____%	CD4 percentage: _____%
Collection date: _____	Collection date: _____	Collection date: _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If yes, provide specimen collection date of earliest positive test for this algorithm: _____
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown
If yes, provide date of diagnosis: _____

Date of Last Documented Negative HIV Test	*Specify Type of Test*

Clinical

Clinical Record Reviewed: ☐ Yes ☐ No

Diagnosed as: ☐ Asymptomatic Date Diagnosed: _____ ☐ Symptomatic Date Diagnosed: _____

Diagnosis	*Dx Date*	*Diagnosis*	*Dx Date*	*Diagnosis*	*Dx Date*
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary*	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary*	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

* If TB selected above, indicate RVCT Case Number:

Treatment/Services Referrals

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown

This patient already has or will be notified about their HIV exposure and counseled by: ☐ Health Department ☐ Physician/Provider ☐ Confirmed Index Case ☐ Unknown

This patient's partners will be notified about their HIV exposure and counseled by: ☐ Health Department ☐ Physician/Provider ☐ Patient ☐ Unknown

This patient is receiving or has been referred for HIV related medical services: ☐ Yes ☐ No ☐ Unknown

This patient is receiving or has been referred for substance abuse treatment services: ☐ Yes ☐ No ☐ Unknown

This patient is receiving or has received antiretroviral medication for HIV treatment: ☐ Yes ☐ No ☐ Unknown

This patient is receiving or has received PCP prophylaxis: ☐ Yes ☐ No ☐ Unknown

This patient has been enrolled in a clinical trial: ☐ NIH- sponsored ☐ Other ☐ None ☐ Unknown

This patient has been enrolled in this clinic: ☐ HRSA- sponsored ☐ Other ☐ None ☐ Unknown

At time of HIV diagnosis medical treatment primarily reimbursed by:
☐ Medicaid ☐ Private insurance/HMO ☐ Other public funding ☐ Clinical trial/Government program
☐ No coverage ☐ Unknown

At time of AIDS diagnosis medical treatment primarily reimbursed by:
☐ Medicaid ☐ Private insurance/HMO ☐ Other public funding ☐ Clinical trial/Government program
☐ No coverage ☐ Unknown

For Female Patients:

This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown

Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown

Has this patient delivered live-born infants?

If yes, estimated due date:			☐ Yes ☐ No ☐ Unknown	
Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)				
Child's Name	*Child's Last Name Soundex*		*Child's Date of Birth*	
Child's Coded ID	*Child's State Number*			
Facility Name of Birth (If child was born at home, enter "home birth")			*Street Address*	
City	*County*	*State*	*ZIP Code*	*Country*
Facility Type	*Inpatient:* ☐ Hospital ☐ Other: _____	*Outpatient:* ☐ Adult HIV Clinic ☐ Private Physician's Office ☐ Other: _____	*Screening, Diagnostic, Referral Agency:* ☐CTS ☐ STD Clinic ☐ Other: _____	*Other Facility:* ☐ Emergency Room ☐ Corrections ☐ Laboratory ☐ Other: _____

HIV Antiretroviral Use History

Main source of antiretroviral (ARV) use information (select one): ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E ☐ Other	*Date patient reported information:*
Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown	
If yes, reason for ARV use (select all that apply):	

	ARV Medications	Date Began	Date of Last Use
☐ HIV Tx			
☐ PrEP			
☐ PEP			
☐ PMTCT			
☐ HBV Tx			
☐ Other:			

HIV Testing History

Main source of testing history information (select one): ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E ☐ Other	*Date patient reported information*
Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown	*Date of first positive HIV test* _____
Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown	*Date of last negative HIV test* _____
Number of negative HIV tests within 24 months before first positive test #_____ ☐ Unknown	

Partner History

Partner Name:		*Date of Birth or Approximate Age:*	
Address:	*City:*	*State:*	*Telephone Number:*
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		***Note for Exposure Dates:*** *Include approximate dates if exact date unknown.*	
Was this partner referred for testing? ☐ Yes ☐ No		*Was this partner tested?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Results* ☐ Positive ☐ Negative ☐ Indeterminant	
Partner Testing Facility			

Partner History cont.

Partner Name:		*Date of Birth or Approximate Age:*	
Address:	*City:*	*State:*	*Telephone Number:*
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		**Note for Exposure Dates:** *Include approximate dates if exact date unknown.*	
Was this partner referred for testing? ☐ Yes ☐ No		*Was this partner tested?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Results* ☐ Positive ☐ Negative ☐ Indeterminant	
Partner Testing Facility			

Partner Name:		*Date of Birth or Approximate Age:*	
Address:	*City:*	*State:*	*Telephone Number:*
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		**Note for Exposure Dates:** *Include approximate dates if exact date unknown.*	
Was this partner referred for testing? ☐ Yes ☐ No		*Was this partner tested?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Results* ☐ Positive ☐ Negative ☐ Indeterminant	
Partner Testing Facility			

Partner Name:		*Date of Birth or Approximate Age:*	
Address:	*City:*	*State:*	*Telephone Number:*
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		**Note for Exposure Dates:** *Include approximate dates if exact date unknown.*	
Was this partner referred for testing? ☐ Yes ☐ No		*Was this partner tested?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Results* ☐ Positive ☐ Negative ☐ Indeterminant	
Partner Testing Facility			

Please Fax Completed Forms to 701.328.0355. Questions Contact NDDoH at 701.328.2378.
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NORTH DAKOTA DEPARTMENT *of* HEALTH