

HIV Case Report Form

Patient Demographics

Patient Last Name		Patient First Name		MI	Medical Record Number	
Address				City of Residence		State
Zip Code		Telephone Number		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Unknown <input type="checkbox"/> Other- specify:		
Soundex (Office Use Only)	Month	Day	Year (4 digit)	<input type="checkbox"/> M <input type="checkbox"/> M - F	Full Social Security Number (enter zeros if no SSN)	
Date of Birth			Gender (check one) <input type="checkbox"/> F <input type="checkbox"/> F - M			

Race

Check all that apply

African American Asian*
 Hispanic/Latino* Native American/Alaskan Native*
 Pacific Islander* White/Caucasian
 *Specify _____

Risk

Check all that apply

Sex with male Sex with female
 IV Drug use Sex with bisexual male
 Sex with IV Drug user Other- specify: _____

HIV Incidence Surveillance

(Please complete date of first positive and last negative in Laboratory Data below)

Check if never had a negative HIV test (this is the first HIV test)

Number of HIV tests in 2 years before first positive:
1 (first positive) + ___ (# prior negative tests) = ___ Total

Ever taken any ARVs (antiretrovirals)? Yes No

On PrEP (Pre-Exposure Prophylaxis) at time of diagnosis? Yes No

First date of ARV use ___/___/___ Last date of ARV ___/___/___

If yes, list ARV medications: _____

Laboratory Data

Required Test ¹	Antibody screen: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab	Lab Name and Accession #:	Mo	Dy	Year
	Supplementary Antibody: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> IFA/Western Blot	Lab Name and Accession #:	Mo	Dy	Year
	<input type="checkbox"/> NAT (Nucleic Acid Test) <input type="checkbox"/> Acute Case (reactive screen, negative supplementary, and positive NAT or detectable viral load)	Lab Name and Accession #:	Mo	Dy	Year
	<input type="checkbox"/> Viral Load: _____ copies/ml Type: _____	Lab Name and Accession #:	Mo	Dy	Year

Recent CD4 Lab Name/Accession #:	Count	Percent	CD4 Test Date			Date of First Positive HIV test			Date of Last Negative HIV test		
			Mo	Dy	Year	Mo	Dy	Year	Mo	Dy	Year

Facility/Provider Information

Facility Name		Facility City		Facility State	
Physician's Name (last, first, MI)				Telephone Number	
Person Completing Form				Telephone Number	
Address			City		State ZIP Code

History with another provider and/or in another region:

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¹To report an HIV case, one of the tests within the "Required Test" area must be checked. A CD4 test is not indicative of HIV infection; however it is useful additional information if a recent test is available. If you are reporting on a test other than a confirmed antibody, but you know the test date of the first confirmed antibody test, please complete the box "Date of First Positive HIV Test".

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