New Hampshire Adult HIV/AIDS Case Report Form (Patients ≥ 13 years of age)

Mail completed form to: NH DHHS Bureau of Infectious Disease,
Attn: Erin Metcalf, 29 Hazen Drive, Concord, NH 03301-6504

I. HIV/AIDS SURVEILLANCE PROGRAM USE ONLY

State Number	Soundex Code	Report Status	Date Received	OOS State Number
		New Update	_____/_____/_____	
Document Source	**New Investigation**	**Report Medium**	**Surveillance Method**	
A_____-_____-_____-_____	Y N U		A F P R U	

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

Patient Name: _____ Phone: ( ) _____-_____
last first middle

Current Address:_____

City:_____County: _____State: _____ Zip: _____

III. FORM INFORMATION

Date form completed:____/____/_____ Person completing form:_____ Phone: ( ) _____-_____
last first

IV. CURRENT PROVIDER INFORMATION

Physician:_____Facility:_____
last first

City:_____ State_____ Phone: ( )_____-_____Med Rec No:_____

V. DEMOGRAPHIC INFORMATION – *complete ALL fields*

Diagnostic Status:	**Sex at Birth:**	**Date of Birth:**	**Country of Birth:**	**Status:**	**Death**
☐ Adult HIV ☐ Adult AIDS	☐ Male ☐ Female	_____/_____/_____	☐ US ☐ US Depend/Posses ☐ Unk ☐ Other_____ _____	☐ Alive ☐ Dead	**Date:** ___/_____/_____ **State of Death:** _____

Marital Status:	**Ethnicity:**	**Race (check all that apply):**
S M W D Oth Unk	Hispanic ☐ Yes ☐ No	☐ Black/African American ☐ White ☐ Asian ☐ Native American or Alaskan Native ☐ Hawaiian/Pacific Islander

Residence at Diagnosis: ☐ Same as Current Street Address:_____
City:_____ County: _____ State: _____ Zip: _____

VI. FACILITY OF DIAGNOSIS

Facility Name:
Physician:

Address:
City:

State:

Facility Type:
☐ Private Physician ☐ ER ☐ CTS
☐ Hospital Inpatient ☐ OB/GYN
☐ Hospital Outpt ☐ Health Dept
☐ STD Clinic ☐ Corrections
Other:_____

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before the 1st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
➢ Sex with male			
➢ Sex with female			
➢ Injected drugs			
➢ Received clotting factor			
➢ ***HETEROSEXUAL contact with the following:***			
• *Injecting Drug User (IDU)*			
• *Bisexual male* ***(applies to females only)***			
• *Person with hemophilia/ coagulation disorder*			
• *Transfusion recipient w/ documented HIV infection*			
• *Person with AIDS or documented HIV infection, risk unspecified*			
➢ Received transfusion Date 1st / Date last: /			
➢ Received organ transplant, tissue or artificial insemination			
➢ Worked in healthcare/clinical lab **OCCUPATION:**			

IX. DOCUMENTED LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (FIRST known pos. test)	RESULT			TEST DATE		
	Pos	Neg	Indet	Mo	Day	Yr
HIV-1 EIA						
HIV1/2 HIV2 EIA						
HIV1 Western Blot						
HIV2 Western Blot						
Other:_____						

POSITIVE HIV DETECTION TEST: (EARLIEST known test)				
☐ NAT	☐ p24 Antigen			
☐ Qual PCR RNA	☐ Qual PCR DNA			

VIRAL LOAD TESTS: (record most recent and earliest)					
Type: (select # below)		COPIES/ML:	Mo	Day	Yr
1-NASBA *2-RT-PCR (stand)* *3-RT-PCR(ultrasen)* *4-bDNA – version* *5-2bDNA – version 3* *6-Other*					

IMMUNOLOGIC LAB TESTS:	Mo	Day	Yr
At or closest to current diagnostic status			
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			
First <200 or <14% of total lymphocytes			
CD4 Count: _____cells/ul (_____%)			
CD4 Count: _____cells/ul (_____%)			

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unk

If YES, provide date of physician documentation	Mo	Day	Yr

X. AIDS INDICATOR DISEASES

Clinical Record Reviewed? ☐ Yes ☐ No Disease:	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
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 carinii pneumonia	____/____/____	☐	☐
Pneumonia, recurrent	____/____/____	☐	☐
Progressive multifocal leukoencephalopathy	____/____/____		☐
Salmonella septicemia, recurrent	____/____/____		☐
Toxoplasmosis of brain	____/____/____	☐	☐
Wasting syndrome due to HIV	____/____/____		☐

XI

XI. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? ☐Yes ☐No ☐ Unk

This patient's partners will be notified about their HIV exposure and counseled by:

- ☐ Health Department
- ☐ Medical
- ☐ Patient
- ☐ Unknown

This patient's medical treatment is primarily reimbursed by:

HIV	AIDS	
☐	☐	Medicaid/Medicare
☐	☐	Private insurance
☐	☐	No coverage
☐	☐	Other public funding
☐	☐	Clinic trial/program
☐	☐	Unknown

	Yes	No	Unk
Is patient enrolled in a clinic/clinical trial?			
Is patient receiving or been referred for:			
• HIV related medical services?			
• Substance Abuse treatment services?			

XII. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services?
☐ Yes ☐ No ☐ Unknown
If YES, physician_____

Is patient currently pregnant?
☐ Yes ☐ No ☐ Unknown
If YES, what is expected due date? _____/_____/_____

Has patient delivered a live-born infant?
☐ Yes ☐ No ☐ Unknown
If YES, provide Grava____ Para____ & info below for most **RECENT** birth
Date of Birth:____/____/_____ Hospital of Birth:_____
City:_____ State:_____ Zip:_____

Child's Name:_____
last first middle

XII. COMMENTS: (Include information about co-infection, testing history

_____
_____
_____
_____

For questions about HIV reporting call 603-271-3932