

PATIENT INFORMATION		
Patient Name ¹ (Last, First, Middle):		
AKA (Nickname, Previous Last Names, etc.)		
Phone #: () -	Social Security #: -- --	
Email:		
Current Street Address:		
City:	Zip Code:	<input type="checkbox"/> Alive <input type="checkbox"/> Dead
Birthdate (mm/dd/yyyy) / /	Death date (mm/dd/yyyy) / /	State of death:
Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Male to Female <input type="checkbox"/> Female <input type="checkbox"/> Female to Male	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never married <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian	
Country of birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____		
If other, date of entry into U.S.: ____/____/____		
Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		
Was the patient dx in another state? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		
<input type="checkbox"/> Outpatient diagnosis ² <input type="checkbox"/> 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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factors for hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion, Transplant, or Insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heterosexual relations with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug user.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual man.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV transfusion or transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV risk not specified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WASHINGTON STATE CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

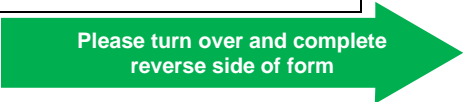
HEALTH DEPARTMENT USE ONLY		
<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS	Steno: _____
Date: ____/____/____		Source: _____
<input type="checkbox"/> New case	<input type="checkbox"/> Progression	<input type="checkbox"/> Update, no status change

HIV DIAGNOSTIC TESTS					
Type of Test <i>At least 2 antibody tests must be indicated for an HIV diagnosis</i> IA = Immunoassay	Collection date	Rapid test	Result (check one per row)		
			Positive/Reactive	Indeterminate	Negative / Non-Reactive
Last Negative Test (prior to HIV diagnosis)	____/____/____				
HIV-1/2 Ag/Ab Lab IA (4 th Gen)	____/____/____				
HIV-1/2 EIA IA (2 nd or 3 rd Gen)	____/____/____				
HIV1/HIV2 Type Differentiating IA <input type="checkbox"/> Multispot <input type="checkbox"/> Geenius	____/____/____		<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Undiff	<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2	<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2
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? <input type="checkbox"/> No <input type="checkbox"/> Yes → Date of documentation by care provider: ____/____/____ <input type="checkbox"/> Unknown					

HIV CARE TESTS ⁴						
HIV VIRAL LOAD TESTS			CD4 LEVELS			
	Test Date	Copies/ml		Test Date	Count	%
Earliest HIV viral load	____/____/____	_____	Earliest CD4	____/____/____	_____ cells/µl	_____ %
Most recent HIV viral load	____/____/____	_____	Most recent CD4	____/____/____	_____ cells/µl	_____ %
EARLIEST DRUG RESISTANCE TEST						
Date: ____/____/____	<input type="checkbox"/> Genotype <input type="checkbox"/> Phenotype		First CD4 <200 µl	____/____/____	_____ cells/µl	_____ %
Laboratory: _____						

OPPORTUNISTIC INFECTIONS ^{4,5}			
	Diagnosis date		Diagnosis date
<input type="checkbox"/> Candidiasis, esophageal	____/____/____	<input type="checkbox"/> Kaposi's sarcoma	____/____/____
<input type="checkbox"/> Cryptococcosis, extrapulmonary	____/____/____	<input type="checkbox"/> Pneumocystis carinii pneumonia	____/____/____
<input type="checkbox"/> Cytomegalovirus disease (other than in liver, spleen, nodes)	____/____/____	<input type="checkbox"/> Wasting syndrome due to HIV	____/____/____
<input type="checkbox"/> Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis	____/____/____	<input type="checkbox"/> Other: _____	____/____/____

^{1,2,3,4}Footnotes on reverse



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

Ever had a previous positive test? Yes
 No
 Unknown

Date of first positive test: ___/___/___

NEGATIVE HIV TESTS

Ever had a negative HIV test? Yes
 No
 Unknown

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
<input type="checkbox"/> HIV treatment	_____	___/___/___	___/___/___
<input type="checkbox"/> PrEP	_____	___/___/___	___/___/___
<input type="checkbox"/> PEP	_____	___/___/___	___/___/___
<input type="checkbox"/> Pregnancy	_____	___/___/___	___/___/___
<input type="checkbox"/> Hep B treatment	_____	___/___/___	___/___/___
<input type="checkbox"/> PCP Prophylaxis	_____	___/___/___	___/___/___
<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
This patient is receiving/has been referred for:				
• HIV related medical service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV Social Service Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Return completed form to:



Snohomish Health District
3020 Rucker Avenue, Ste. 202
Everett, WA 98201
425.339.5261 or FAX 425.339.8707
www.snohd.org/Providers/Disease-Reporting

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 Infectious Disease Prevention Section Field Services, DOH, at (360) 236-3482 or (360) 236-3484, or your local health department. In King County, please call Public Health Seattle & King County, at (206) 263-2410.

Comments: