I. PATIENT INFORMATION

Patient's Name *(Last, First, M.I.)*: _____ Telephone Number ( ) _____

Address: _____ City: _____ County: _____ State: _____ ZIP Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security Number*: _____ ***- Patient identifier information is not transmitted to CDC!***

* This agency is requesting disclosure of your Social Security Number (SSN) in accordance with IC 16-41-2; disclosure is voluntary and you will not be penalized for refusal.

INDIANA DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

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

State Form 51201 (R5 / 9-25)

II. STATE HEALTH DEPARTMENT USE ONLY

State Patient Number: ☐☐☐☐☐☐☐☐☐☐

Date Form Completed:_____/_____/_____

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: *(check one)*

☐ HIV Infection (not AIDS)

☐ AIDS

AGE AT DIAGNOSIS:

☐☐ Years

☐☐ Years

DATE OF BIRTH: Month ☐☐ Day ☐☐ Year ☐☐

CURRENT STATUS: ☐ Alive ☐ Dead

DATE OF DEATH: Month ☐☐ Day ☐☐ Year ☐☐

STATE/TERRITORY OF DEATH: _____

SEX

☐ Male

☐ Female

ETHNICITY *(select one)*:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Unknown

RACE *(select one or more)*:

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian/or Other Pacific Islander

☐ White

☐ Multiracial

Height: _____ Weight: _____

COUNTRY OF BIRTH:

☐ U.S.

☐ U.S. Dependencies and Possessions (incl. Puerto Rico)
(specify) _____

☐ Other
(specify): _____

RESIDENCE AT DIAGNOSIS:

City: _____ County: _____ State/Country: _____ ZIP Code: ☐☐☐☐☐ - ☐☐☐☐

DIAGNOSED OR TREATED IN ANY OTHER STATE(S)/COUNTRY?: State: _____ Country: _____

IV. FACILITY OF FIRST DIAGNOSIS

_____
Facility Name

_____
City State/Country

FACILITY TYPE *(check one)*

☐ Physician, HMO

☐ Case Management Agency

☐ HRSA Clinic

☐ Counseling & Testing Site

☐ Drug treatment center

☐ Prenatal/OB clinic

☐ Correction facility

☐ Hospital, Inpatient

☐ Hospital, Outpatient

☐ Other *(specify)*: _____

V. PHYSICIAN/PROVIDER COMPLETING FORM

Current Physician/Provider

Name: _____ Telephone Number: _____
(Last, First, MI)

Name of Facility or Practice: _____ Medical Record Number: _____

Complete Address: _____

City_____ State _____ ZIP _____

Person Completing Form: _____ **Telephone Number:** _____

- Physician identifier information is not transmitted to CDC! -

VI. PATIENT HISTORY

BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON HAD:
(Respond to ALL categories.)

	Yes	No
• Sex with male	☐	☐
• Sex with female	☐	☐
• Injected nonprescription drugs	☐	☐
• Worked in a health-care or clinical laboratory setting ..... *(specify occupation)* _____	☐	☐
• Received transfusion of blood/blood components (other than clotting factor)..... First ____/____ Mo Yr Last ____/____ Mo Yr	☐	☐
• Received transplant of tissue/organs or artificial insemination.....	☐	☐
• 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:

	Yes	No	Unk
• Intravenous/injection drug user	☐	☐	☐
• Bisexual male.....	☐	☐	☐
• Person with hemophilia/coagulation disorder	☐	☐	☐
• Transfusion recipient with documented HIV infection	☐	☐	☐
• Transplant recipient with documented HIV infection, risk not specified	☐	☐	☐
• Person with AIDS or documented HIV infection, risk not specified.....	☐	☐	☐

VII. LABORATORY DATA

Test 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV 1/2 AG/AB ☐ EIA 1/2 ☐ Western blot ☐ HIV-2 RNA/DNA NAAT (Qual)
☐ Qualitative differentiated Immunoassay
___HIV-1 AB ___HIV-2 AB **Collection Date:** __ __ /__ __ /__ __ __ __
Result : ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate

Test 2: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV 1/2 AG/AB ☐ EIA 1/2 ☐ Western blot ☐ HIV-2 RNA/PCR (Quantitative viral load)
☐ Qualitative differentiated Immunoassay
___HIV-1 AB ___HIV-2 AB **Collection Date:** __ __ /__ __ /__ __ __ __
Result : ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate

HIV Detection Tests (Quantitative viral load): ☐ HIV-1 RNA/PCR (Quantitative viral load) ☐ HIV-2 RNA/PCR (Quantitative viral load)
Result: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to current diagnostic status: CD4 count: _____ **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

First CD4 result <200 or <14% CDR count: CD4 count: _____ CD**4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Def	Pres.	Initial Date *(mo/day/yr)*	AIDS INDICATOR DISEASES	Def	Pres.	Initial Date *(mo/day/yr)*
1) Candidiasis, bronchi, trachea, or lungs		NA		14) Lymphoma, Burkitt's (or equivalent term)		NA	
2) Candidiasis, esophageal				15) Lymphoma, immunoblastic (or equivalent term)		NA	
3) Carcinoma, invasive cervical		NA		16) Lymphoma, primary in brain		NA	
4) Coccidioidomycosis, disseminated or extrapulmonary		NA		17) *Mycobacterium avium* complex or M. Kansasii disseminated or extrapulmonary			
5) Cryptococcosis, extrapulmonary		NA		18) *M. tuberculosis, pulmonary**			
6) Cryptosporidiosis, chronic intestinal (>1 month duration)		NA		19) *M. tuberculosis*, disseminated or extrapulmonary*			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)		NA		20) *Mycobacterium*, of other species or unidentified species,disseminated or extrapulmonary			
8) Cytomegalovirus retinitis (with loss of vision)				21) *Pneumocystis carinii* pneumonia			
9) HIV encephalopathy		NA		22) *Pneumonia*, recurrent, in twelve (12) month period			
10) Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis or esophagitis		NA		23) Progressive multifocal leukoencephalopathy	NA		
11) Histoplasmosis, disseminated or extra pulmonary		NA		24) Salmonella septicemia, recurrent	NA		
12) Isosporiasis, chronic intestinal (>1 month duration)		NA		25) Toxoplasmosis of brain			
13) Kaposi's sarcoma				26) Wasting syndrome due to HIV	NA		

Def. + definitive diagnosis Pres.+ presumptive diagnosis *RVCT CASE NO:_____

IX. TREATMENT/SERVICES REFERRALS

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

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

_____ DIS (Local Health Department) _____Physician/provider

_____Patient _____IDOH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

- HIV-related medical services…….. Yes No Unk.
- Substance Abuse treatment services…. Yes No Unk.

This patient received or is receiving:

	Yes	No	Unk.
▪ Anti-retroviral therapy	☐	☐	☐
▪ PCP prophylaxis …	☐	☐	☐

This patient has been enrolled at:

Clinical Trial	Clinic
☐ NIH-sponsored	☐ HRSA-sponsored
☐ Other	☐ Other
☐ None	☐ None
☐ Unknown	☐ Unknown

This patient's medical treatment is primarily reimbursed by:

_____Medicaid _____Private Insurance/HMO

_____No Coverage _____Other Public Funding

_____Clinical trial/government program _____Unknown

X. FOR FEMALES ONLY

Is the patient currently pregnant? ☐ Yes ☐ No

Obstetrician/NP/Clinic/Family Doctor:_____ Telephone Number ( )_____

Due Date: _____/_____/_____

Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ☐ Yes ☐ No

If additional space is needed, please complete in the "Comments" section.

XI. HIV TESTING HISTORY

This section is to be completed using information obtained during patient interview. If a patient interview is not conducted, information may be obtained via medical chart abstraction.

Date of interview *(mo/day/yr)*: ____/____/____

Ever had a previous Positive HIV test? ☐ Yes ☐ No ☐ Refused ☐ Unknown Date of first positive HIV test *(mo/day/yr)*: ___/___/___

Was this positive test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Refused ☐ Unknown Date of last negative HIV test *(mo/day/yr)*: ___/___/___

Was the last negative test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown

Number of negative HIV tests within twenty-four (24) months before first positive test: _____ ☐ Refused

How many of these negative test results were from self-tests performed by the patient? _____

Ever taken any antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown If yes, name of the earliest ARV medication taken: _____

Date ARV's first began *(mm/dd/yy)*: ___/___/___ Date of last ARV use (mm/dd/yy) ___/___/___

Ever taken Pre-exposure Prophylaxis (PREP)? ☐ Yes ☐ No ☐ Refused ☐ Unknown If yes, name of PREP medication taken: _____

Dates PREP first began *(mm/dd/yy)*: ___/___/___ Date of last PREP use (mm/dd/yy) ___/___/___

XII. POST-TEST COUNSELING

As required by law : IC 35-42-1-7

	Yes	No	
Has the patient been told not to donate blood, plasma, organs, or other body tissue?	☐	☐	Date *(mo/day/yr)* _____
Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior?	☐	☐	Date *(mo/day/yr)* _____

MUST COMPLETE:

Name of person that provided post-test counseling _____ Telephone Number: ( ) _____

XIII. COINFECTION/PARTNERS

COINFECTIONS	Yes	No	Unk.	Diagnosis Date	Acute ☐	Chronic ☐
Hepatitis B	☐	☐	☐	_____		
Hepatitis C	☐	☐	☐	_____		
Sexually Transmitted Infection (STI)	☐	☐	☐	_____	Specify STI: _____	
Sexually Transmitted Infection (STI)	☐	☐	☐	_____	Specify STI: _____	
Sexually Transmitted Infection (STI)	☐	☐	☐	_____	Specify STI: _____	

If you have any questions when completing this form, please call : 1-800-376-2501

Please **mail** form to:

Reports for Residents of **ALL COUNTIES** should be sent to:
Office of Clinical Data and Research
Indiana Department of Health
2 N. Meridian Street, 8th Floor
Indianapolis, IN 46204

DO NOT FAX.

COMMENTS: