



**LAB DATA**

AB Test at Dx	First (+)	Collect Date	Last (-)	Collect Date
	mm	dd	mm	dd
H-1 IFA	Pos		Neg	
H-1 WB	Pos		Neg	
Rapid	Pos		Neg	
H EIA-1	Pos		Neg	

First Positive Detection Test  
 Test Type (select one) mm dd yyyy  
 P24 Antigen  RNA PCR (Qual)  Culture  Proviral DNA (Qual) **Pos** [ ] [ ] [ ]

Immunologic Lab tests: T Count Pct mm dd yyyy  
 Most current T count [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 1<sup>st</sup> <200/<14% T count [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

If Lab tests are not documented, is diagnosis documented by physician?  Yes  No  Unk

If Yes, provide date of physician documentation: mm dd yyyy  
 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

First Detectable VL: Test Type (select one) VL mm dd yyyy  
 NASBA  RT-PCR  bDNA  Other [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Clinical Record Reviewed  Yes  No

**TREATMENT AND SERVICES REFERRALS**

	Yes	No	Unk	N/A
Patient informed of his/her infection?	Y	N	U	
Patient's partners will be notified about HIV exposure and counseled by: [1]-Health Department [2]-Physician/Provider [3]-Patient [9]-Unknown				
Patient has been receiving or has received:				
▪ HIV related medical services	Y	N	U	
▪ Substance abuse treatment services	Y	N	U	N/A
▪ Anti-retroviral therapy	Y	N	U	
▪ PCP prophylaxis	Y	N	U	

Patient's primary source of health insurance at time of HIV diagnosis :

Medicaid	Private insurance, unspecified
Medicare	State funded, unspecified
Other public funding	VA
No health insurance	Unknown

**HIV Testing and Treatment History Information (TTH)**

1. Main Source of testing and treatment history information [2] Patient Interview [1] Provider Report [3] Medical Record Review [5] Other

2. Date patient reported information [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (mm/dd/yyyy)

3. Ever had a previous positive HIV test?  Yes  No  Refused  Don't know

4. Date of first positive HIV test [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (mm/dd/yyyy)

5. Ever had a negative HIV test?  Yes  No  Refused  Don't know

6. Date of last negative (most recent) HIV test [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (mm/dd/yyyy)

7. Number of negative HIV tests in the 2 years before 1<sup>st</sup> positive test [ ] [ ] (Enter "R" for Refused, "D" for Don't know)

8. Ever taken any antiretroviral medications (ARVs)?  Yes  No  Refused  Don't know

9. If yes, list ARV used: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

10. First date any ARV used: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (mm/dd/yyyy)

11. Last date any ARV used: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (mm/dd/yyyy)

18. Reason(s) why tested when received 1<sup>st</sup> positive HIV result:

a. Concerned about exposure to H in the 6 months before 1<sup>st</sup> positive result  Yes  No  Refused  Don't know

b. Were getting tested for H routinely (for example every 6 months)  Yes  No  Refused  Don't know

c. Were just checking to make sure are H negative  Yes  No  Refused  Don't know

d. Were required to test (court order, insurance, military, etc)  Yes  No  Refused  Don't know

e. Had some other reasons  Yes, specify: \_\_\_\_\_  No  Refused  Don't know

**Local Fields**

Was last HIV negative conducted in SF?  Yes  No  Refused  Don't know

If yes, list the name of site in SF: \_\_\_\_\_

**INSTRUCTIONS FOR COMPLETION OF "HIV CONFIDENTIAL CASE REPORT FORM"**

Complete all questions for which information is available.

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- 1) **Ethnicity:** Check one response for Hispanic or Not Hispanic. Hispanic persons are of Spanish origin, descent or culture, regardless of race.
- 2) **Race:** Check one or more.
- 3) **Country of birth:** Please complete this item, even if born in the United States.
- 4) **Patient History:** Please check "yes", "no", or "unk" for each category.
- 5) **Laboratory Data:** Please complete the entire section. HIV antibody test, first available viral load report and CD4 test. If the patient has a positive HIV antibody test but there is no laboratory slip available, please note this in the appropriate section.
- 6) **Treatment and services referrals:** Please complete the section to the best of your knowledge.

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- 7) **HIV Testing History:** Please complete all questions-see above. If you have any questions about this section of the form you may call Tony Buckman, at 415-554-9074.

**This case report may be phoned in (415-554-9050), hand delivered or sent by TRACEABLE mail to:**

San Francisco Department of Public Health  
Statistics & Epidemiology  
**Attn: Viva Delgado**  
25 Van Ness Avenue, Suite 500  
San Francisco, CA 94102

If you have any questions concerning this form or HIV/AIDS reporting, please contact the Statistics and Epidemiology Section at 415-554-9050.

**LEGAL AUTHORITY TO COLLECT INFORMATION AND ASSURANCES OF PATIENT CONFIDENTIALITY.**

It is fully consistent with California law for medical center employees to cooperate with representatives of the Public Health Officer in reporting HIV/AIDS cases. Section 2643.5 of the California Health and Safety Code includes HIV as a reportable condition and further stipulates the health facilities "may establish administrative procedures to assure that reports are made to the local health department without duplication." The confidentiality of Medical Information Act (California Civil Code Section 56.10(b)(7) and 56.30(c) states that patient medical information may be disclosed without prior authorization when specifically required by law such as in compliance with communicable disease reporting requirements. Section 199.21(1) of the Health and Safety Code state the results of HIV tests may be included in medical records and may be disclosed to the Public Health Officer in accordance with the AIDS case reporting requirements. Patient information gathered by the AIDS Surveillance Branch is held in accordance with the AIDS Public Health Record Confidentiality Act (Section 199.42 Health and Safety Code).