San Francisco Adult HIV Confidential Case Report

(for patients ≥ 13 years of age at time of diagnosis)

Return completed form to state/local health department

25 Van Ness Ave., #500
San Francisco, CA 94102
Tel: 415-554-9050

EHARS ______ EHX _____ Incidence _____

Health Department Use Only

Date Received: __ __/__ __/__ __ __ __ (MM/DD/YYYY)		Document Source: A__ __. __ __. __ __	Document UID:
New Investigation ☐ **Y**es ☐ **N**o ☐ **U**nk		Reporting Health Department	State Patient Number
Report Medium	Surveillance Method	State: **CA** City/County: **San Francisco**	
[**1**] Field Visit [**2**] Mailed	☐ **A**ctive ☐ **F**ollow-up ☐ **U**nk	Date Form Completed:	City/County Patient Number
[**4**] Phone	☐ **P**assive ☐ **R**eabstraction	__ __/__ __/__ __ __ __ (MM/DD/YYYY)	

Patient Identification and Address. These data will not be transmitted outside the state health department.

Patient's Name (Last, First, Middle)		Alias Name (Last, First, Middle)		
Address	City	County	State	ZIP Code

SSN: __ __ __- __ __ - __ __ __ __

Alias SSN: __ __ __- __ __ - __ __ __ __

Other ID: Lab report number: __ __ __ __ __ __ __ __ __ __ C&T Number: __ __ __ __ __ __ __ __ __ __ __

Medical Record Number: ______________________________

DEMOGRAPHIC INFORMATION

Dx Stat at Report	Date of Birth (Mo/Day/Year)	Country of Birth	Vital Status
[**1**] HIV [**2**] AIDS	__ __ / __ __ / __ __ __ __ Alias DOB: __ __ / __ __ / __ __ __ __	☐ US ☐ US Dep & Terr, specify__________ ☐ Other, specify __________ ☐ Unk	[**1**] Alive [**2**] Dead

Sex at Birth	If TG, Gender	Ethnicity	Race (Check one or more):
☐ **M**ale ☐ **F**emale	☐ **M→F** ☐ **F→M**	[**Y**] Hispanic [**N**] Not Hisp/Latino [**U**] Unk	☐ Am Ind/Alask Nat ☐ Native HI/Other PI ☐ White ☐ Black/Afr Am ☐ Asian ☐ Unk Extended Race: __________

Residence at HIV Diagnosis ☐ Same address as patient address

City__________________ County__________________ State/Country__________________ Zip ☐☐☐☐☐

FACILITY OF HIV DIAGNOSIS

Facility name

City **State**

Facility Setting (check one) :

☐ Public ☐ Private ☐ Federal ☐ Unk

Facility Type (check one):

☐ HIV Counseling and Testing site

☐ STD clinic

Outpatient Facility:

☐ Private physician ☐ Adult HIV clinic

☐ Other clinic

☐ Other facility (specify):__________________

☐ Unknown

PATIENT HISTORY

After 1977 & before first positive HIV antibody test or AIDS diagnosis	Yes	No	Unk
Sex with male	Y	N	U
Sex with female	Y	N	U
Injected nonprescription drugs	Y	N	U
Received clotting factor for hemophilia/coagulation disorder, specifically: [**1**]-Factor VIII (Hemophilia A) [**2**]-Factor IX (Hemophilia B) [**3**]-Other Specify:__________	Y	N	U
HETEROSEXUAL relations with any of the following:			
▪ Intravenous/injection drug user	Y	N	U
▪ Bisexual male	Y	N	U
▪ Person with hemophilia/coagulation disorder	Y	N	U
▪ Transfusion recipient with documented HIV infection	Y	N	U
▪ Transplant recipient with documented HIV infection	Y	N	U
▪ Person with AIDS or documented HIV infection, NIR	Y	N	U
Received transfusion of blood/blood components (not clotting factor) First: ____ /____ /______ (Mo Day Year) Last: ____ /____ /______ (Mo Day Year)	Y	N	U
Received transplant of tissue/organ alternative insemination	Y	N	U
Worked in a healthcare or clinical laboratory setting Specify occupation__________________	Y	N	U

LAB DATA

AB Test at Dx	First (+)	Collect Date mm	dd	yyyy	Last (-)	Collect Date mm	dd	yyyy
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					
1st <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 1st 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 1st positive HIV result:
    a. Concerned about exposure to H in the 6 months before 1st 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 <u>TRACEABLE</u> 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).