Georgia Adult HIV/AIDS Confidential Case Report Form

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

If reporting HIV and AIDS on the same patient, please complete a separate form for each diagnosis.

I. STATE HEALTH DEPARTMENT USE ONLY

Document ID	**State No**
GA00-______________________	______________

Date Form Completed: _____/_____/________ (mm dd yyyy)

Return completed form to:
Georgia Division of Public Health, Epi Section
P.O. Box 2107
Atlanta, GA 30301
Phone: 1-800-827-9769
http://health.state.ga.us/epi/hivaids

II. PATIENT IDENTIFIER INFORMATION—*Data NOT transmitted to CDC*

Patient Name:________________________________ (last first middle) **Alias:**______________ **Maiden:**_____________

Current Address:______________________________________ **City:**____________________ **State:**_____

County: ___________________ **Zip:**__________ **Phone** (   ) _____-________ **Social Security** _____-____-_____

III. REPORTING FACILITY INFORMATION

Provider Name:________________________________ (last first degree) **Facility:**______________________________

Address______________________________________ **City:**____________________ **State:**_____ **Zip:**__________

Med Rec No: _____________ **Person completing form:**____________________________ **Phone** (   ) _______-________

Is the reporting facility also the facility of initial diagnosis? □Yes □No **If no, also complete Section IX on reverse side.**

IV. DEMOGRAPHIC INFORMATION—*Complete ALL fields*

Diagnostic Status:
☐Adult HIV
☐Adult AIDS

Sex at Birth:
☐Male ☐Female

Transgender (if applicable):
☐Male to Female
☐Female to Male

Date of Birth:
_____/_____/________ (mm dd yyyy)

Country of Birth:
☐US ☐Unknown
☐US Depend/Territory *Specify:* ________________
☐Other, *Specify:* ________________

Vital Status:
☐Alive
☐Deceased

Date of Death:
____/____/______ (mm dd yyyy)

State of Death: _________

Residence at Diagnosis: □**Same as current**
Address:____
City:____________________State:______Zip:__________

Race (check all that apply):
☐Black/African-American ☐White
☐Native Amer/AK Native ☐Asian
☐Hawaiian/Pac Island ☐Unknown
☐Other: ______________________

Ethnicity:
Hispanic/Latino:
☐Yes ☐No
☐Unknown

V. PATIENT HISTORY—*Complete ALL fields*

BEFORE the first positive HIV test or diagnosis, patient EVER had:	**Yes**	**No**	**Unk**
Sex with male			
Sex with female			
Injected drugs			
Received clotting factor			
HETEROsexual relations with the following:			
Injection 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 / Last: /			
Received organ transplant, tissue or artificial insemination			
Worked in healthcare/clinical laboratory If yes, **SPECIFY OCCUPATION:**			
Was patient infected perinatally?			

VI. DOCUMENTED LABORATORY DATA

TYPE OF TEST	RESULT			TEST DATE	
HIV Antibody Tests at Diagnosis (FIRST known positive test)					
	+	-	Indet.	Mo	Yr
HIV-1 EIA					
HIV-1/HIV-2 EIA					
HIV-1 Western Blot					
Earliest Positive HIV Detection Test				Mo	Yr
□ Qual PCR DNA □ p24 antigen					
□ Qual PCR RNA □ NAT					
CD4 Count	cells/μl	%		Mo	Yr
At or closest to HIV diagnosis					
First <200 or <14% OR at first AIDS OI					
Detectable HIV Viral Load	Type*	Copies/mL		Mo	Yr
Earliest					
Most Recent					
***Specify Type**: **1**-NASBA, **2**-RT-PCR (standard) **3**-RT-PCR (ultrasen), **4**-bDNA-v. 2, **5**-bDNA-v. 3				Mo	Yr
Physician Diagnosis: If HIV lab tests were not documented, is HIV diagnosis documented by a physician? □**Yes** □**No**					

Georgia Adult HIV/AIDS Confidential Case Report Form (continued)

VII. AIDS INDICATOR DISEASES (ONLY COMPLETE FOR DIAGNOSED DISEASES)

Clinical Record Reviewed?	Initial Date	Initial Diagnosis		RVCT Case No	Initial Date	Initial Diagnosis	
☐ Yes ☐ No	(mo/yr)	Definitive	Presumptive	___________	(mo/yr)	Definitive	Presumptive
Candidiasis, bronchi, trachea, or lungs	/		n/a	Lymphoma, Burkitt's (or equivalent term)	/		n/a
Candidiasis, esophageal	/			Lymphoma, immunoblastic (or equivalent term)	/		n/a
Carcinoma, invasive cervical	/		n/a	Lymphoma, primary in brain	/		n/a
Coccidioidomycosis, disseminated or extrapulmonary	/		n/a	*Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary	/		
Cryptococcosis, extrapulmonary	/		n/a	*M. tuberculosis*, pulmonary	/		
Cryptosporidiosis, chronic intestinal (>1mo. duration)	/		n/a	*M. tuberculosis*, disseminated or extrapulmonary	/		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	/		n/a	*Mycobacterium,* of other or unidentified species, disseminated or extrapulmonary	/		
Cytomegalovirus retinitis (with loss of vision)	/			*Pneumocystis* pneumonia	/		
HIV encephalopathy	/		n/a	Pneumonia, recurrent, in 12 month period	/		
Herpes simplex: chronic ulcers (>1 mo. duration), or bronchitis, pneumonitis, or esophagitis	/		n/a	Progressive multifocal leukoencephalopathy	/		n/a
Histoplasmosis, disseminated or extrapulmonary	/		n/a	Salmonella septicemia, recurrent	/		n/a
Isosporiasis, chronic intestinal (>1mo. duration)	/		n/a	Toxoplasmosis of brain	/		
Kaposi's sarcoma	/			Wasting syndrome due to HIV (10% weight loss with diarrhea OR chronic weakness and fatigue for 30 days)	/		n/a

VIII. TREATMENT/SERVICES REFERRALS

Is patient aware of infection? ☐Yes ☐ No ☐ Unknown

PARTNER NOTIFICATION:

The Georgia Division of Public Health (GDPH) offers HIV-positive patients partner notification and linkage to care services. Please indicate if you would like GDPH to contact this patient and offer partner notification.

☐ Yes
☐ No, provider will offer.

This patient's HIV medical treatment is primarily reimbursed by:

☐ Ryan White
☐ Medicare/Medicaid
☐ Private Insurance
☐ No coverage
☐ Other public funding
☐ Clinical trial/program
☐ Unknown

Has patient received or is receiving antiretroviral therapy? ☐ Yes ☐ No ☐ Unknown

Is patient receiving or been referred for:

HIV related medical services? ☐ Yes ☐ No ☐ Unknown

Substance abuse treatment services? ☐ Yes ☐ No ☐ Unknown

IX. FACILITY OF DIAGNOSIS—*if different from Sec. III*

____
Facility Name

____
Address

____
City State Zip

X. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services?

☐ Yes ☐ No ☐ Unknown

If Yes, provider:______________________

Is patient currently pregnant?

☐ Yes ☐ No ☐ Unknown

If Yes, list EDC (due date):____/____/_______

Has patient delivered a live-born infant?

☐ Yes ☐ No ☐ Unknown

If Yes, how many times since HIV infection? _____

Date of most RECENT birth: ____/____/_______

Hospital:______________________

City__________ State______Zip__________

Child's name: ______________________
Last First Middle

XI. COMMENTS

____

____

____

____

Revised 4/09. This form substitutes CDC 50.42A Rev. 03/07 OMB No. 0920-0573 Exp 2/28/10.