CLINICAL AIDS

Disease	Diagnosis Date (mm/dd/yyyy)	dx method[5] Presumptive	dx method[5] Definitive
Candidiasis, bronchi, trachea, or lungs	___/___/_____		☐
Candidiasis, esophageal	___/___/_____	☐	☐
Cervical cancer, invasive	___/___/_____		☐
Coccidioidomycosis, disseminated or extrapulmonary	___/___/_____		☐
Cryptococcosis, extrapulmonary	___/___/_____		☐
Cryptosporidiosis, chronic[6] intestinal	___/___/_____		☐
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/_____		☐
Cytomegalovirus retinitis (with loss of vision)	___/___/_____	☐	☐
HIV encephalopathy	___/___/_____		☐
Herpes simplex: chronic[6] ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/_____		☐
Histoplasmosis, diss. or extrapulmonary	___/___/_____		☐
Isosporiasis, chronic[6] 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[7]	___/___/_____	☐	☐
Progressive multifocal leukoencephalopathy	___/___/_____		☐
Salmonella septicemia, recurrent	___/___/_____		☐
Toxoplasmosis of brain	___/___/_____	☐	☐
Wasting syndrome due to HIV[8]	___/___/_____		☐

Return completed form to:

Snohomish Health District STD Clinic
3020 Rucker Avenue, Suite 106
Everett, WA 98201
(425) 339-5298 or FAX to (425) 339-8707

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]If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.

[6]Chronic: more than one month's duration.

[7]Recurrent: 2 or more episodes within a 1-year period.

[8]Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code

FUI Assigned:

☐ Complete	☐ Incomplete	☐ OOS

RVCT Number:

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 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 HIV/AIDS Prevention & Education Services, Washington State Department of Health, at (360) 236-3422, or your local health department.

Comments:

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #: ( ) -

Social Security #: - -

Current Street Address:

City:

Zip Code:

[1] Alive
[2] Dead

Birthdate (mm/dd/yyyy) / /

Death Date (mm/dd/yyyy) / /

State of Death:

Sex at birth:
[1] Male
[2] Female

Gender or identity change:
[1] Male to Female
[2] Female to Male

Ethnicity:
[1] Hispanic
[2] Not Hispanic

Race (check all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ American Indian/Alaska Native

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Never married
- ☐ Unknown

Country of birth: ☐ U.S. ☐ Other: _____

If other, length of residence in US: _____

Was patient dx in another state? [1] Yes [2] No
If yes, specify state:

Residence at time of diagnosis if different than current address:
City: County: Zip Code:

Med. Record #/Patient Code:

Name & City of facility of diagnosis:

[1] Outpatient dx[2] [2] Inpatient dx[2]

PROVIDER INFORMATION

Physician: Phone: City:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977[3]

Check all that apply	Yes	No	Unk
Sex with male……	☐	☐	☐
Sex with female……	☐	☐	☐
Injection drug use……	☐	☐	☐
Received clotting factors for hemophilia……	☐	☐	☐
Transfusion, Transplant, or Insemination……	☐	☐	☐
Heterosexual relations with:			
Injection drug user……	☐	☐	☐
Bisexual man……	☐	☐	☐
Person with hemophilia……	☐	☐	☐
PWA/HIV transfusion or transplant….	☐	☐	☐
PWA/HIV risk not specified……..	☐	☐	☐
Worked in health-care or laboratory setting..	☐	☐	☐

If yes, occupation: _____

LABORATORY DATA[4]

Test Date (mm/dd/yyyy)

Last documented negative test ___/___/____ Type of test:

EARLIEST POSITIVE HIV ANTIBODY TESTS:

Type of Test:	Test Date (mm/dd/yyyy)	
HIV-1 EIA	___/___/____	☐ Test not done
HIV-1 Western Blot or IFA	___/___/____	☐ Test not done

HIV VIRAL LOAD TESTS:

Type of Test: Test Date (mm/dd/yyyy)

Earliest HIV Viral Load ____/____/_____ ☐ Copies per mL _____ ☐ Undetectable

Most recent HIV Viral Load ____/____/_____ ☐ Copies per mL _____ ☐ Undetectable

OTHER HIV TESTS

Type of test: Rapid, Antigen, Culture, HIV-2, _____

Date (mm/dd/yyyy): ___/___/_____ Result:

PHYSICIAN DIAGNOSIS OF INFECTION:

No laboratory tests are available but Physician documents HIV infection Date (mm/dd/yyyy): ___/___/____

EARLIEST DRUG RESISTANCE TEST

Date (mm/dd/yyyy): ___/___/____ ☐ Test not done

Type: Genotype Phenotype

Laboratory: _____

CD4 LEVELS

Type of Test:	Test Date (mm/dd/yyyy)	Count	Percent
Earliest CD4	___/___/_____	_____cells/µl	_____%
Most Recent CD4	___/___/_____	_____cells/µl	_____%
First CD4 <200 µl or < 14%	___/___/_____	_____ cells/µl	_____%

TREATMENT / SERVICES REFERRALS

	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	☐	☐	☐	
This patient is receiving/has been referred for:	☐	☐	☐	
• HIV related medical service	☐	☐	☐	
• HIV Social Service Case Management	☐	☐	☐	
• Substance abuse treatment services	☐	☐	☐	☐
This patient received/ is receiving:				
• Antiretroviral (ARV) therapy	☐	☐	☐	
If yes, earliest date started ARV after diagnosis (mm/dd/yyyy): ____/____/____				
• PCP prophylaxis	☐	☐	☐	

FOR WOMEN

	Yes	No	Unk
Is this patient currently pregnant?	☐	☐	☐

Expected delivery date (mm/dd/yyyy) _____/_____/_____

HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno: _____

Date: _____ / _____ /_____ Source: _____

☐ New Case ☐ Progression ☐ Update, no status change

Note AIDS indicator diseases on reverse

☐ CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES
If checked, skip Clinical AIDS section on reverse.

HIV TESTING HISTORY

Complete this section if new diagnosis or new patient

OR attach completed questionnaire ☐ ***Not applicable***

Date of information collected (mm/dd/yyyy): ____/____/_____

Information from: ☐ patient interview ☐ review of medical record

FIRST SELF-REPORTED POSITIVE HIV TEST

Date (mm/yyyy): _____/_____ State: _____

Registration type: ☐ Confidential ☐ Anonymous ☐ Unk/Refused

LAST SELF-REPORTED NEGATIVE HIV TEST

☐ Never had negative HIV test ☐ Unk *(Skip to next section)*

Date (mm/yyyy): _____/_____

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1 (first positive test) + _____ (# of negative tests during prior 2 years) = _____ (total # of tests in 2 years)

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV

	Yes	No	Unk
Used ARV in 6 months before diagnosis:	☐	☐	☐

If yes: Names of medications used:

_____

Continue in comments on reverse if necessary

First date of ARV use (mm/dd/yyyy): _____/_____/_____

	Yes	No	Unk
Currently using ARV:	☐	☐	☐

If no: Last date of ARV use (mm/dd/yyyy): _____/_____/_____

DRUG USE

Methamphetamine use? ☐ Yes ☐ No ☐ Unk

If, yes: ☐ Injection ☐ Non-injection, specify: _____ ☐ Unk

PARTNER NOTIFICATION (PN)

For ***previously unreported HIV/AIDS cases***, WAC 246-100-072 indicates that the local health officer or designee is required to contact the health care provider within 7 days to offer partner notification assistance.

Health care provider has been contacted to offer PN assistance. ☐ Yes ☐ No

If no, reason not contacted: _____

Disposition:

☐Health care provider accepts assistance from LHJ in conducting PN.

☐Health care provider assumes responsibility for working with patient to conduct PN activities.

[1, 2, 3, 4] Footnotes on reverse

Revised 8/1/2007