New Hampshire Adult HIV/AIDS Case Report Form (for patients ≥13 years of age) Fax completed form to: (603) 696-3017

I. HIV/AIDS SURVEILLANCE PROGRAM USE ONLY

State Number	Soundex Code	Report Status	Date	Date Received			OOS State Number		
		New Update			_				
Document Source	New Investigation	Report Mediu	um Surveillance Method						
A	Y N U			Α	F	Р	R	U	
I. PATIENT IDENTIFIER INFORMA	ATION – data not transn	nitted to CDC							

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Document Source		New Investigation		Report Medi	Report Medium		Surveillance Method					
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II. PATIENT IDENTIFI	FR INFORMA	ATION – da	nta not trans	smitted to CDC								
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Current Address:											-	
City:			County:		State:		Zip	:			_	
III. FORM INFORMAT	ION											
Date form completed	d: / /	Pers	on completin	g form:		Pł	none: ()	-			
·			·	last	first			,			_	
V. CURRENT PROVI	DER INFORM	IATION										
Physician:				Facility:							_	
last		first		Phone: ()								
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V. DEMOGRAPHIC IN	IFORMATION	l – comple	te ALL field	ls								
Diagnostic Status:	Sex at Birtl	n: Date	of Birth:	Country of B			atus: Alive	Death	,	,		
☐ Adult HIV	☐ Male			□ Us □ U.	ther		- -	_	/_ of Death:	<i>'</i> —	_	
Adult AIDS	☐ Female	:	_!!				Dead					
Marital Status:	Ethni			Race (check all that								
S M W D Oth Ur	nk Hispa	nic L Yes	☐ No	☐ Black/African Ame		White	As	ian n/Pacific Is	slander			
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				et Address:				n.		—		
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VI. FACILITY OF DIA	GNUSIS			NT HISTORY - COMP			io potic	ont had:	Υ	N	11	
Facility Name:				:he 1 st positive HIV vith male	test/AIDS	uiagnos	is, patie	ent nad:	 	IN	U	
Physician:				vith famala						-	\vdash	

VI. FACILITY OF DIAGNOSIS	_ VII. PATIENT HISTORY – COMPLETE ALL FIELDS						
Facility Name:	Before the 1 st positive HIV test/AIDS diagnosis, patient had:						
Physician:	➤ Sex with male						
Address	➤ Sex with female						
Address:	➤ Injected drugs						
City:	➤ Received clotting factor						
State:	> HETEROSEXUAL contact with the following:						
	Injecting Drug User (IDU)						
Facility Type:	Bisexual male (applies to females only)						
☐ Private Physician ☐ ER ☐ CTS	Person with hemophilia/ coagulation disorder						
☐ Hospital Inpatient ☐ OB/GYN	Transfusion recipient w/ documented HIV infection						
☐ Hospital Outpt ☐ Health Dept ☐ STD Clinic ☐ Corrections	Person with AIDS or documented HIV infection, risk unspecified						
Other:	➤ Received transfusion Date 1 st / Date last: /						
	➤ Received organ transplant, tissue or artificial insemination						

> Worked in healthcare/clinical lab OCCUPATION:

IX. DOCUMENTED LABORATORY DATA HIV ANTIBODY TESTS AT DIAGNOSIS: (FIRST known pos. test) **IMMUNOLOGIC LAB TESTS:** RESULT TEST DATE At or closest to current diagnostic status Yr Pos Neg Indet Мо Day HIV-1 EIA CD4 Count: cells/ul (%) HIV1/2 HIV2 EIA CD4 Count: cells/ul (%) HIV1 Western Blot First <200 or <14% of total lymphocytes HIV2 Western Blot CD4 Count: cells/ul (%) Other: CD4 Count: cells/ul (%) POSITIVE HIV DETECTION TEST: (EARLIEST known test) **PHYSICIAN DIAGNOSIS:** NAT p24 Antigen If HIV lab tests were not documented, is HIV diagnosis Qual PCR DNA documented by a physician? Yes No Qual PCR RNA VIRAL LOAD TESTS: (record most recent and earliest) Мо Yr Day COPIES/ML: If YES, provide date of physician documentation Type: (select # below) Day Yr 1-NASBA 2-RT-PCR (stand) XI. TREATMENT/SERVICES REFERRALS 3-RT-PCR(ultrasen) 4-bDNA – version 5-2bDNA – version 3 X. AIDS INDICATOR DISEASES Clinical Record Reviewed? Initial This patient's partners will be This patient's medical treatment Definitive ☐ Yes ☐ No **Dx Date** notified about their HIV is primarily reimbursed by: exposure and counseled by: Disease: (mo/day/yr) HIV AIDS П Medicaid/Medicare Candidiasis, bronchi, trachea, or lungs ☐ Health Department Candidiasis, esophageal Private insurance ☐ Medical Cervical cancer, invasive No coverage ☐ Patient Coccidioidomycosis, disseminated or Other public funding extrapulmonary ☐ Unknown Clinic trial/program Cryptococcosis, extrapulmonary Unknown Cryptosporidiosis, chronic intestinal Cytomegalovirus disease (other than liver, Yes No Unk spleen, or nodes) Is patient enrolled in a clinic/clinical trial? Cytomegalovirus retinitis (with loss of vision) Is patient receiving or been referred for: HIV encephalopathy П Herpes simplex: chronic ulcers; or bronchitis, · HIV related medical services? pneumonitis, or esophagitis Substance Abuse treatment services? Histoplasmosis, diss. or extrapulmonary Isosporiasis, chronic intestinal ΧI Kaposi's sarcoma Lymphoma, Burkitt's (or equivalent) П XII. WOMEN ONLY Lymphoma, immunoblastic (or equivalent) 1 1 Is patient receiving or been referred for OB/GYN services? Lymphoma, primary in brain Yes No Unknown Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary If YES, physician Is patient currently pregnant? M. tuberculosis, pulmonary Yes No Unknown M. tuberculosis, diss. or extrapulmonary П If YES, what is expected due date? Mycobacterium of other or unidentified species, Has patient delivered a live-born infant? diss. or extrapulmonary Yes No Unknown Pneumocystis carinii pneumonia П П If YES, provide Grava____ Para_ & info below for most RECENT birth Pneumonia, recurrent \Box Date of Birth: ___/___ Hospital of Birth:_

XII. COMMENTS: (Include information about co-infection, testing history

City:

Child's Name:___

last

State:____

first

Zip:

middle

П

Progressive multifocal leukoencephalopathy

Salmonella septicemia, recurrent

Wasting syndrome due to HIV

Toxoplasmosis of brain