



**IX. DOCUMENTED LABORATORY DATA**

<b>HIV ANTIBODY TESTS AT DIAGNOSIS: (FIRST known pos. test)</b>						
	<b>RESULT</b>			<b>TEST DATE</b>		
	Pos	Neg	Indet	Mo	Day	Yr
HIV-1 EIA						
HIV1/2 HIV2 EIA						
HIV1 Western Blot						
HIV2 Western Blot						
Other: _____						
<b>POSITIVE HIV DETECTION TEST: (EARLIEST known test)</b>						
<input type="checkbox"/> NAT	<input type="checkbox"/> p24 Antigen					
<input type="checkbox"/> Qual PCR RNA	<input type="checkbox"/> Qual PCR DNA					
<b>VIRAL LOAD TESTS: (record most recent and earliest)</b>						
Type: (select # below)	COPIES/ML:			Mo	Day	Yr
1-NASBA						
2-RT-PCR (stand)						
3-RT-PCR(ultrasen)						
4-bDNA - version						
5-2bDNA - version 3						
6-Other						

<b>IMMUNOLOGIC LAB TESTS:</b>			
<i>At or closest to current diagnostic status</i>			
	Mo	Day	Yr
CD4 Count: _____ cells/ul ( _____%)			
CD4 Count: _____ cells/ul ( _____%)			
<i>First &lt;200 or &lt;14% of total lymphocytes</i>			
CD4 Count: _____ cells/ul ( _____%)			
CD4 Count: _____ cells/ul ( _____%)			
<b>PHYSICIAN DIAGNOSIS:</b>			
If HIV lab tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
	Mo	Day	Yr
If YES, provide date of physician documentation			

**X. AIDS INDICATOR DISEASES**

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
Disease:			
Candidiasis, bronchi, trachea, or lungs	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>

**XI. TREATMENT/SERVICES REFERRALS**

Patient informed of his/her infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
This patient's partners will be notified about their HIV exposure and counseled by:		This patient's medical treatment is primarily reimbursed by:	
<input type="checkbox"/> Health Department	<input type="checkbox"/> Medical	<input type="checkbox"/> Patient	<input type="checkbox"/> Unknown
<input type="checkbox"/> Medicaid/Medicare	<input type="checkbox"/> Private insurance	<input type="checkbox"/> No coverage	<input type="checkbox"/> Other public funding
<input type="checkbox"/> Clinic trial/program	<input type="checkbox"/> Unknown		
	Yes	No	Unk
Is patient enrolled in a clinic/clinical trial?			
Is patient receiving or been referred for:			
• HIV related medical services?			
• Substance Abuse treatment services?			

XI

**XII. WOMEN ONLY**

Is patient receiving or been referred for OB/GYN services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, physician _____
Is patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, what is expected due date? ___/___/___
Has patient delivered a live-born infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, provide Grava ___ Para ___ & info below for most RECENT birth Date of Birth: ___/___/___ Hospital of Birth: _____ City: _____ State: _____ Zip: _____ Child's Name: _____ last _____ first _____ middle _____

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

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For questions about HIV reporting call: (603) 271-4496