I. PATIENT INFORMATION

Patient's Name *(Last, First, M.I.)*: _____ Telephone Number: ( ) _____

Address: _____ City: _____ County: _____ State: _____ ZIP Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security Number*: _____ ***- Patient identifier information is not transmitted to CDC! -***

* This agency is requesting disclosure of your Social Security Number (SSN) in accordance with IC 16-41-2; disclosure is voluntary and you will not be penalized for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

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

State Form 51201 (R4 / 2-20)

II. STATE HEALTH DEPARTMENT USE ONLY

State Patient Number: ☐☐☐☐☐☐☐☐☐☐

Date Form Completed:_____/_____/_____

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: *(check one)*

☐ HIV Infection (not AIDS)

☐ AIDS

AGE AT DIAGNOSIS:

☐☐ Years

☐☐ Years

DATE OF BIRTH: Month ☐☐ Day ☐☐ Year ☐☐

CURRENT STATUS: ☐ Alive ☐ Dead

DATE OF DEATH: Month ☐☐ Day ☐☐ Year ☐☐

STATE/TERRITORY OF DEATH: _____

SEX (at birth):

☐ Male

☐ Female

Transgendered

☐ Male to Female

☐ Female to Male

ETHNICITY *(select one)*:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Unknown

RACE *(select one or more)*:

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian/or Other Pacific Islander

☐ White

☐ Multiracial

Height: _____ Weight: _____

COUNTRY OF BIRTH:

☐ U.S.

☐ U.S. Dependencies and Possessions (incl. Puerto Rico)
(specify) _____

☐ Other *(specify)*: _____

RESIDENCE AT DIAGNOSIS:

City: _____ County: _____ State/Country: _____ ZIP Code: ☐☐☐☐☐ - ☐☐☐☐

DIAGNOSED OR TREATED IN ANY OTHER STATE(S)/COUNTRY?: State: _____ Country: _____

IV. FACILITY OF FIRST DIAGNOSIS

_____
Facility Name

_____
City State/Country

FACILITY TYPE *(check one)*

☐ Physician, HMO

☐ Case Management Agency

☐ HRSA Clinic

☐ Counseling & Testing Site

☐ Drug treatment center

☐ Prenatal/OB clinic

☐ Correction facility

☐ Hospital, Inpatient

☐ Hospital, Outpatient

☐ Other *(specify)*: _____

V. PHYSICIAN/PROVIDER COMPLETING FORM

Current Physician/Provider

Name: _____ Telephone Number: _____
(Last, First, MI)

Name of Facility or Practice: _____ Medical Record Number: _____

Complete Address: _____

City_____ State _____ ZIP _____

Person Completing Form: _____ **Telephone Number:** _____

- Physician identifier information is not transmitted to CDC! -

VI. PATIENT HISTORY

BEFORE THE FIRST POSITIVE HIV TEST OR AIDS DIAGNOSIS, THIS PERSON HAD:
(Respond to ALL categories.)

	Yes	No
• Sex with male	☐	☐
• Sex with female	☐	☐
• Injected nonprescription drugs	☐	☐
• Worked in a health-care or clinical laboratory setting *(specify occupation)* _____	☐	☐
• Received transfusion of blood/blood components (other than clotting factor) First ____/____ Mo Yr Last ____/____ Mo Yr	☐	☐
• Received transplant of tissue/organs or artificial insemination	☐	☐
• Received clotting factor for hemophilia/coagulation disorder Specify disorder: ☐ Factor VIII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other *(Specify)* _____	☐	☐

HETEROSEXUAL relations with any of the following:

	Yes	No	Unk
• Intravenous/injection drug user	☐	☐	☐
• Bisexual male	☐	☐	☐
• Person with hemophilia/coagulation disorder	☐	☐	☐
• Transfusion recipient with documented HIV infection	☐	☐	☐
• Transplant recipient with documented HIV infection, risk not specified	☐	☐	☐
• Person with AIDS or documented HIV infection, risk not specified	☐	☐	☐

VII. LABORATORY DATA

Test 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture ☐ EIA ½ ☐ IFA ☐ Western Blot
☐ Qualitative differentiated Immunoassay (i.e.Multispot) **Result :** ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

Test 2: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture ☐ EIA ½ ☐ IFA ☐ Western Blot
☐ Qualitative differentiated Immunoassay (i.e.Multispot) **Result :** ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis.
Test 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)
Result: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Test 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)
Result: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)
CD4 at or closest to current diagnostic status: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __
First CD4 result <200 cells/µL or <14%: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Documentation of Tests
*Complete below **only** if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]:*

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
- If **YES**, provide date (specimen collection date if known) of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician prior to 2006? ☐ Yes ☐ No If **YES**, provide date of diagnosis: __ __ /__ __ /__ __ __

PLEASE ATTACH A COPY OF ALL HIV LABS (INCLUDING ANY GENOTYPE AND/OR PHENOTYPE).

VIII. CLINICAL STATUS

Clinical Record Reviewed: ☐ Yes ☐ No | **Def. = definitive diagnosis** **Pres. = presumptive diagnosis** | Enter Date Patient was diagnosed as: Asymptomatic: ____/____/____ Symptomatic (not AIDS): ____/____/____

AIDS INDICATOR DISEASES	Def	Pres.	Initial Date *(mo/day/yr)*	AIDS INDICATOR DISEASES	Def	Pres.	Initial Date *(mo/day/yr)*
1) Candidiasis, bronchi, trachea, or lungs		NA		14) Lymphoma, Burkitt's (or equivalent term)		NA	
2) Candidiasis, esophageal				15) Lymphoma, immunoblastic (or equivalent term)		NA	
3) Carcinoma, invasive cervical		NA		16) Lymphoma, primary in brain		NA	
4) Coccidioidomycosis, disseminated or extrapulmonary		NA		17) *Mycobacterium avium* complex or M. Kansasii disseminated or extrapulmonary			
5) Cryptococcosis, extrapulmonary		NA		18) *M. tuberculosis, pulmonary**			
6) Cryptosporidiosis, chronic intestinal (>1 month duration)		NA		19) *M. tuberculosis*, disseminated or extrapulmonary*			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)		NA		20) *Mycobacterium*, of other species or unidentified species,disseminated or extrapulmonary			
8) Cytomegalovirus retinitis (with loss of vision)				21) *Pneumocystis carinii* pneumonia			
9) HIV encephalopathy		NA		22) *Pneumonia*, recurrent, in twelve (12) month period			
10) Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis or esophagitis		NA		23) Progressive multifocal leukoencephalopathy	NA		
11) Histoplasmosis, disseminated or extra pulmonary		NA		24) Salmonella septicemia, recurrent	NA		
12) Isosporiasis, chronic intestinal (>1 month duration)		NA		25) Toxoplasmosis of brain			
13) Kaposi's sarcoma				26) Wasting syndrome due to HIV	NA		
				*RVCT CASE NUMBER:			

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? …….. ☐ Yes ☐ No

This patient's partners will be notified about their HIV exposure and counseled by: ☐ DIS (Local Health Department ☐ Physician/provider ☐ Patient ☐ ISDH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

	Yes	No	Unk.
• HIV-related medical services……	☐	☐	☐
• Substance abuse treatment services……..	☐	☐	☐

This patient received or is receiving:

	Yes	No	Unk.
▪ Anti-retroviral therapy	☐	☐	☐
▪ PCP prophylaxis …	☐	☐	☐

This patient has been enrolled at:

Clinical Trial	Clinic
☐ NIH-sponsored	☐ HRSA-sponsored
☐ Other	☐ Other
☐ None	☐ None
☐ Unknown	☐ Unknown

This patient's medical treatment is primarily reimbursed by:

☐ Medicaid	☐ Private insurance/HMO
☐ No coverage	☐ Other Public Funding
☐ Clinical trial/government program	☐ Unknown

X. FOR FEMALES ONLY

Is the patient currently pregnant? ☐ Yes ☐ No	Obstetrician/NP/Clinic/Family Doctor: _____
Due Date: _____/_____/_____	Telephone Number: ( ) _____
Is provider aware of her HIV status? ☐ Yes ☐ No	Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ☐ Yes ☐ No ☐ Unk

If additional space is needed, please complete in the "Comments" section.

Name of Child(ren) *(Born since original diagnosis)*: _____ Date(s) of Birth: _____/_____/_____

Hospital Name: _____ City: _____ State: _____

Has the child been tested for HIV? ☐ Yes ☐ No If yes, what was the result? _____ Was the child born before the mother's last negative HIV test? ☐ Yes ☐ No

XI. HIV TESTING HISTORY

This section is to be completed using information obtained during patient interview. If a patient interview is not conducted, information may be obtained via medical chart abstraction.

Date of interview *(mo/day/yr)*: ____/____/____

Ever had a previous Positive HIV test? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Date of first positive HIV test *(mo/day/yr)*: ___/___/___

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Date of last negative HIV test *(mo/day/yr)*: ___/___/___

Number of negative HIV tests within twenty-four (24) months before first positive test: Number:_____ ☐ Refused ☐ Don't Know/Unknown

Ever taken any antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown

If yes, name of the earliest ARV medication taken: _____

Dates ARVs taken – Date first began *(mo/day/yr)*: ___/___/___

Dates ARVs taken – Date of last use *(mo/day/yr)*: ___/___/___

XII. POST-TEST COUNSELING

As required by law : IC 35-42-1-7

	Yes	No	
Has the patient been told not to donate blood, plasma, organs, or other body tissue?	☐	☐	Date *(mo/day/yr)* _____
Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior?	☐	☐	Date *(mo/day/yr)* _____

MUST COMPLETE:

Name of person that provided post-test counseling _____ Telephone Number: ( ) _____

XIII. COINFECTION/PARTNERS

COINFECTIONS	Yes	No	Unk.	Diagnosis Date	Acute	Chronic	
Hepatitis B	☐	☐	☐	_____	☐	☐	
Hepatitis C	☐	☐	☐	_____			
Sexually Transmitted Disease (STD)	☐	☐	☐	_____			Specify STD: _____
Sexually Transmitted Disease (STD)	☐	☐	☐	_____			Specify STD: _____
Sexually Transmitted Disease (STD)	☐	☐	☐	_____			Specify STD: _____

Does the patient have partners they would like to have ISDH assist them in notifying? (If additional space is needed, please complete in the "Comments" section.)

Name:	Address:	Telephone Number:	Email:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

If you have any questions when completing this form, please call : 1-800-376-2501

Please **mail** form to:

Reports for Residents of **Elkhart, Jasper, Lake, Laporte, Newton, Porter and St. Joseph Counties** should be sent to:
Lake County Health Department
Attention: HIV/AIDS Surveillance Project Director
2900 West 93rd Street
Crown Point, IN 46307

Reports for Residents of **All Remaining Counties** should be sent to:
Office of Clinical Data and Research
Indiana State Department of Health
2 North Meridian Street, 6-C
Indianapolis, IN 46204

DO NOT FAX.

COMMENTS: