WASHINGTON STATE CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno:_____

Date: ____/____/_____ Source: _____

☐ New case ☐ Progression ☐ Update, no status change

PATIENT INFORMATION

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

AKA (Nickname, Previous Last Names, etc.)

Phone #: ( ) -

Social Security #: -- --

Email:

Current Street Address:

City: | Zip Code: | ☐ Alive ☐ Dead

Birthdate (mm/dd/yyyy) / / | Death date (mm/dd/yyyy) / / | State of death:

Sex at birth: ☐ Male ☐ Female

Current gender identity: ☐ Male ☐ Female ☐ Male to Female ☐ Female to Male

Ethnicity: ☐ Hispanic ☐ Not Hispanic

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

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

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

If other, date of entry into U.S.: ____/____/_____

Language: ☐ English ☐ Other: _____

Was the patient dx in another state? ☐ Yes ☐ No

If yes, specify state: _____

Residence at time of diagnosis if different than current address:

Medical Record # / Patient Code:

Name & City of facility of diagnosis:

☐ Outpatient diagnosis[2] ☐ Inpatient diagnosis[2]

PROVIDER INFORMATION

Physician: Phone:

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	☐	☐	☐

HIV DIAGNOSTIC TESTS

Type of Test *At least 2 antibody tests must be indicated for an HIV diagnosis* IA = Immunoassay	**Collection date**	Rapid test	**Result** (check one per row) Positive/ Reactive	Indeterminate	Negative / Non-Reactive
Last Negative Test (prior to HIV diagnosis)	___/___/_____				
HIV-1/2 Ag/Ab Lab IA (4th Gen)	___/___/_____				
HIV-1/2 EIA IA (2nd or 3rd Gen)	___/___/_____				
HIV1/HIV2 Type Differentiating IA ☐ Multispot ☐ Geenius	___/___/_____		☐ HIV-1 ☐ HIV-2 ☐ Undiff	☐ HIV-1 ☐ HIV-2	☐ HIV-1 ☐ HIV-2
HIV-1 Western Blot	___/___/_____				
HIV-1 RNA/DNA Qualitative NAAT	___/___/_____				
OTHER: _____	___/___/_____				

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider?

☐ No

☐ Yes → Date of documentation by care provider: _____/_____/_____

☐ Unknown

HIV CARE TESTS[4]

HIV VIRAL LOAD TESTS

	Test Date	Copies/ml
Earliest HIV viral load	___/___/___	_____
Most recent HIV viral load	___/___/___	_____

EARLIEST DRUG RESISTANCE TEST

Date: ___/___/___ ☐ Genotype ☐ Phenotype

Laboratory:_____

CD4 LEVELS

	Test Date	Count	%
Earliest CD4	___/___/___	____cells/µl	_____%
Most recent CD4	___/___/___	____cells/µl	_____%
First CD4 <200 µl	___/___/___	____cells/µl	_____%

OPPORTUNISTIC INFECTIONS[4,5]

	Diagnosis date		Diagnosis date
☐ Candidiasis, esophageal	___/___/___	☐ Kaposi's sarcoma	___/___/___
☐ Cryptococcosis, extrapulmonary	___/___/___	☐ Pneumocystis carinii pneumonia	___/___/___
☐ Cytomegalovirus disease (other than in liver, spleen, nodes)	___/___/___	☐ Wasting syndrome due to HIV	___/___/___
☐ Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis	___/___/___	☐ Other: _____	___/___/___

Please turn over and complete reverse side of form

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

HIV TESTING AND TREATMENT HISTORY

Date patient reported info: ____/____/_____

Information from: ☐ Patient interview ☐ Review of medical record ☐ Provider report ☐ PEMS ☐ Other

FIRST POSITIVE HIV TEST	NEGATIVE HIV TESTS
Ever had a previous positive test? ☐ Yes ☐ No ☐ Unknown	Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown
Date of first positive test: ____/____/_____	Date of last negative test: ____/____/_____
	Number of negative HIV tests in 24 months before first positive test: _____

HISTORY OF HIV-RELATED MEDICATIONS (check all that apply)

Ever taken any antiretroviral medications (ARVs)? ☐ Yes ☐ No ☐ Unknown

Reason	Name(s) of medication(s)	Date began	Date of last use
☐ HIV treatment	_____	____/____/_____	____/____/_____
☐ PrEP	_____	____/____/_____	____/____/_____
☐ PEP	_____	____/____/_____	____/____/_____
☐ Pregnancy	_____	____/____/_____	____/____/_____
☐ Hep B treatment	_____	____/____/_____	____/____/_____
☐ PCP Prophylaxis	_____	____/____/_____	____/____/_____
☐ Other	_____	____/____/_____	____/____/_____

DRUG USE

Methamphetamine use? ☐ Yes → ☐ Injection ☐ Non-injection, specify: _____ ☐ Unk ☐ No ☐ Unknown

TREATMENT/SERVICES REFERRALS

	Yes	No	Unk	N/A
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	☐	☐	☐	☐

FOR WOMEN

Is patient currently pregnant? ☐ Yes → Expected delivery date: ____/____/_____ ☐ No ☐ Unknown

FOR HEALTH DEPARTMENT USE ONLY

Stateno: Date received: _____/_____/_____

Case report completed/verified by:

☐ Complete ☐ Incomplete ☐ OOS

RVCT Number:

Please return completed form to:

Office of Infectious Disease
Assessment Unit
PO Box 47838
Olympia, WA 98504-7838
(360) 236-3464

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] Opportunistic illnesses include: Candidiasis, bronchi, trachea, or lungs; Candidiasis, esophageal; Cervical cancer, invasive; Coccidioidomycosis, disseminated or extrapulmonary; Cryptococcosis, extrapulmonary; Cryptosporidiosis, chronic intestinal; Cytomegalovirus disease (other than liver, spleen, or nodes); Cytomegalovirus retinitis (with loss of vision); HIV encephalopathy; Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis; Histoplasmosis, diss. or extrapulmonary; Isosporiasis, chronic 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; Progressive multifocal leukoencephalopathy; Salmonella septicemia, recurrent; Toxoplasmosis of brain; Wasting syndrome due to HIV

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 a 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 Infectious Disease Prevention Section Field Services, DOH, at (360) 236-3482 or (360) 236-3484, or your local health department. In King County, please call Public Health Seattle & King County, at (206) 263-2410.

Comments: