

STICKY #:26-

Michigan Adult HIV Confidential Case Report Form*(Patients ≥ 13 years of age at time of diagnosis)*

Surveillance Date Entered:

I. SURVEILLANCE USE ONLY

DCH FORM #1355 Modified February 2016

Document ID	Soundex Code	Date Received at Surveillance	State Number
MI00-		____/____/____	
Document Source	Report Status	Report Medium	Surveillance Method
	New Update		A F P R

II. PATIENT IDENTIFIER INFORMATION

Patient Legal Name Last: _____ First: _____ Middle: _____
 Alias Maiden Last: _____ First: _____ Middle: _____

Address Type: Residential Correctional P.O. Temporary Homeless Shelter Foster Home
Current Address: _____ City: _____ County: _____
 State: _____ Zip: _____ Phone: _____ Mobile: _____ SS#: _____

Residence at Diagnosis (check all that apply): Residence at HIV diagnosis Residence at Stage 3 (AIDS) diagnosis
 Same as Current Address Address: _____
 City: _____ County: _____ State/Country: _____ Zip: _____

III. FACILITY OF DIAGNOSIS

Site of 1st Positive test for HIV Diagnosis Site of Stage 3 (AIDS) Diagnosis

Facility Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Provider Name Last: _____ First: _____ Provider Specialty: _____
 Facility Type: Private Provider Hosp Inpt Hosp Out ED ID Clinic LHD CBO CTR Other

VI. CURRENT PROVIDER OF HIV CARE (Same as Facility of Diagnosis)

Provider Name Last: _____ First: _____ Facility: _____
 City: _____ State: _____ Zip: _____ Phone: _____ Med Rec No: _____

V. FACILITY PROVIDING INFORMATION (Same as Facility of Diagnosis) (Same as Current Provider of Care)

Date Form Completed: _____/_____/_____ Person Completing Form: _____
 Facility Completing Form: _____ Phone: _____

VI. DEMOGRAPHIC INFORMATION – COMPLETE ALL FIELDS

Case Status: HIV Infection Stage 3 (AIDS) Do you suspect this is an acute (recent) infection? Y N

Sex at Birth	Gender Identity	Date of Birth	Country of Birth	Vital Status	Death Date	Marital Status
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans to Female <input type="checkbox"/> Trans to Male	____/____/____ Alias DOB ____/____/____	<input type="checkbox"/> US <input type="checkbox"/> Unk Other (specify): _____	<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	____/____/____ State/Terr of Death: _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Lives w/ Ptnr

Race: Black (African American) White Asian American Indian/Alaskan Native Hawaiian/PI

Ethnicity: Arab Y N Unk Latino/Hispanic Y N Unk

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before HIV Diagnosis, patient had:	Y	N	Unk	Before HIV Diagnosis, patient had:	Y	N	Unk
Sex with a male				HETEROSEXUAL SEX WITH:			
Sex with a female				- An injection drug user (IDU)			
Injected non-prescription drugs				- A bisexual male (females only)			
Transplant/transfusion/clotting disorder*				- Person known to have HIV/AIDS			

*and is claiming this as their source of HIV infection

High risk sex (detail in comment section)				Was patient perinatally infected?			
---	--	--	--	-----------------------------------	--	--	--

VIII. TREATMENT/SERVICES REFERRALS (MI law requires providers to notify known partners or request help from LHD)

Patient Informed of HIV infection? Y N Unk
 Patient's partners will be notified of exposure and counseled by: Local Health Department Clinical Care Provider

IX. WOMEN ONLY

Patient currently pregnant? Y N Unk IF YES, referred to OB? Y N Unk EDC (Due Date): ____/____/____
 Patient delivered live infants? Y N Unk IF YES, Most Recent Delivery Date: ____/____/____
 Delivery Hospital: _____ City: _____ State: _____ Child Name: _____

X. DOCUMENTED LAB DATA

PATIENT NAME: _____

Questions concerning lab results? CALL US at 248 424-7922 or 517 335-8165

You may add copies of lab results to this form and may fax form to 248 424-9161(SE MI) or 517 335-8121

HIV DIAGNOSTIC TESTS – please report all positive and subsequent negative tests											
Type of Test ***At least 2 Antibody Tests must be indicated for an HIV diagnosis*** IA = ImmunoAssay	Collection Date	Rapid Test	Positive or Reactive	Reactive for Ag	Reactive for Ab	HIV1 Ab Positive	HIV 2 Ab Positive	Indeterminate	Undifferentiated	Negative or NonReactive	Manufacturer
HIV-1/2 Ag/Ab Lab IA (4 th Gen Discriminating)		N									
HIV-1/2 Ag/Ab Rapid IA (4 th Gen Discriminating)		Y									Alere Determine
HIV-1/2 Ag/Ab Lab IA (4 th Gen)		N									
HIV-1/2 Ab IA (2 nd or 3 rd Gen)		Y N									
HIV1/HIV 2 Type Differentiating IA		Y									Multispot or Geenius
HIV-1 Western Blot		N									
HIV-1 RNA/DNA Qualitative NAAT		N									
OTHER: _____											
Last Negative Test (prior to HIV diagnosis)		Y N									

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider? Yes No Unk
 IF YES, please provide date of documentation by care provider: _____/_____/_____

HIV CARE TESTS

HIV-1 RNA Assay Quantitative Viral Load
 Detectable Undetectable Copies/mL _____ Collection Date _____/_____/_____
 Detectable Undetectable Copies/mL _____ Collection Date _____/_____/_____

CD4 Count at or closest to current diagnostic status
 CD4 Count _____ cells/ul CD4 Percentage _____ % Collection Date _____/_____/_____

First CD4 Count <200 total lymphocytes
 CD4 Count _____ cells/ul CD4 Percentage _____ % Collection Date _____/_____/_____

HIV Genotype
 Sanger Sequence Deep or NextGen Sequence Collection Date _____/_____/_____

XI. STAGE 3 (AIDS) OPPORTUNISTIC ILLNESSES (See Instructions for a list of opportunistic illnesses)

Name of Opportunistic Illness: _____ Illness Diagnosis Date _____/_____/_____

XII. HIV TESTING AND TREATMENT HISTORY (TTH)

Date questions answered by patient: _____/_____/_____

Main Source of TTH Info: Medical Record Review Patient Interview Provider Report Other

<p>First Positive Test Reported by Patient: Ever have previous positive HIV test? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk Date of 1st positive HIV test: _____/_____/_____ Anonymous 1st positive test? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk</p>	<p>Negative Tests Reported by Patient: Ever test negative? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk Date of most recent negative test: _____/_____/_____ # of negative tests in 24 mo. before 1st positive test: _____ <input type="checkbox"/> Unk</p>
--	--

History of ANY Antiretroviral Treatment (ARV) Use: CHECK HERE IF NO ARV USE EVER:

For HIV Tx? <input type="checkbox"/> ARV used: _____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For PrEP? <input type="checkbox"/> ARV used: _____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For PEP? <input type="checkbox"/> ARV used: _____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For Preg mom? <input type="checkbox"/> ARV used: _____ Date began: _____/_____/_____ Date of last use: _____/_____/_____
For Hep B Tx? <input type="checkbox"/> ARV used: _____ Date began: _____/_____/_____ Date of last use: _____/_____/_____

Currently using ARV? Yes, Date of most recent use: _____/_____/_____ No, Date of last use: _____/_____/_____

XIII. COMMENTS _____