Adult HIV/AIDS Case Report Form (ACRF) Instructions
California Department of Public Health

Purpose of ACRF

The Adult HIV/AIDS Case Report Form (CDPH 8641A [12/12]) is designed to collect information that promotes public health understanding of HIV infection morbidity and mortality among California residents **greater than or equal to 13 years of age** at time of diagnosis. California Health and Safety (H&S) Code Sections 121022 and 120130 authorize HIV/AIDS reporting by health care providers, laboratories, local health officers (LHOs), and the Office of AIDS (OA), Center for Infectious Diseases, California Department of Public Health (CDPH). The ACRF is used by health care providers and local public health department HIV surveillance staff for HIV and stage 3 (AIDS) reporting.

Unlike case-based data management, document-based data management allows all documents to be stored and retained electronically in their original formats. Instead of completing one form for a given reported case, fill out the applicable part of the form for each data source contributing to that HIV or stage 3 (AIDS) case.

Patients for whom the ACRF is indicated

- Each person with newly diagnosed HIV, stage 0, 1, 2, 3 (AIDS), or unknown stage.
- Each person with HIV infection progressing from an earlier or unknown stage to stage 3 (AIDS) diagnosis.
- When an HIV-infected patient dies, use this form to report the new information (if there is no death certificate available).
- Each person with HIV infection, who has been reported but for which updated information is available, such as: additional risk factor information or updated address information.

For a patient to be accepted by the Centers for Disease Control and Prevention (CDC) as a case the following items must be present: STATENO, Last Name Soundex, DOB (at minimum the year), Sex at Birth, Vital Status or Date of Death, Ethnicity/Race and Confirmatory Lab or Physician Diagnosis. It is always best to provide as much information as you can but critical for those seven elements. A case must always be submitted to our office whether the seven elements are present or not; more information can be gathered later.

Response Options

For all instances on the ACRF, answers of “Yes” will be interpreted as if the event in question has occurred. Answers of “No” will be interpreted as if the event in question did NOT apply/occur (only select NO if medical record specifically states this). Answers of “Unknown” will be interpreted as if the investigation failed to yield an answer. If an investigation for a particular item was not performed, then leave it blank.

Disposition of form

Submit the completed ACRF to the Office of AIDS using the required double envelope system and through traceable mail until CalREDIE is in production. Once your LHJ have the appropriate permissions, then the LHJ will use the ACRF in CalREDIE to report the case data. Data obtained is entered into the CDC Enhanced HIV/AIDS Reporting System (eHARS) and then transferred

by OA, (without identifiers), to the CDC by encrypted electronic transfer via a secure data network.

I. HEALTH DEPARTMENT USE ONLY – (See the ACRF in Appendix 1.0)

1. Provide the name and phone number for the individual who complete the form. This person can be a physician, nurse, physician's assistant or local health jurisdiction (LHJ) staff.

2. STATENO-Enter the California state number.
   For new cases, the STATENO is assigned from the state number log at the LHJ. These numbers are generated by Ron Ramos, Ron.Ramos@cdph.ca.gov, at OA surveillance.

   Each patient should have a unique state number throughout the course of HIV disease in each state where reported. Assigned numbers **should not** be reused, even if the case is later deleted. This variable is used, along with the state of report, to uniquely identify cases reported to CDC and to merge the state datasets without duplication.

3. City Number – CITYNO (Optional)
   Enter the assigned city/county patient number (cityno are assigned by the LHJ). Each patient may have a unique city/county number throughout the course of HIV disease assigned by the separately funded city in which reported. Assigned numbers **should not** be reused, even if the case is later deleted.

4. Date Form Completed-Enter date in *mm/dd/yyyy* format.
   Provide the date the ACRF was completed

5. Reporting Health Department – County Name
   Enter name of city and county of the health department that receives the report from providers of surveillance data.

6. Document Source- (see Appendix 2 for document source codes)
   Enter the code for the document source that provided the information for this report (See appendix for document source codes).

7. Report Status
   Check the appropriate box for if this is a New or Updated case.

8. Complete the physician's name, phone number and hospital/facility name. This may or may not be the same physician or facility that provided testing.

9. Did This Report Initiate a New Case Investigation?
   Enter whether this case report initiated a new investigation by the health department

10. Surveillance Method
    Enter the method the case report was ascertained- active, passive, follow up, re-abstraction, or unknown.

11. Report Medium
Enter the medium in which the case report was submitted. Choose one of the following options: field visit, mail, phone, electronic transfer, or CD/disk.

II. PATIENT IDENTIFICATION

1. Enter the patient's full legal, alias name and/or maiden name. Patient identifier information is for state/local health department use only and is not transmitted to the CDC.
2. Complete address type, current address, phone number, and social security number.
3. Enter any additional patient's ID type and the number of the other ID such as: medical record number, prison number, Report of Verified Case of Tuberculosis (RVCT) case number, and Counseling and Testing Number.

III. PATIENT DEMOGRAPHICS

1. Sex at Birth
Select patient's biological sex assigned at birth.
2. Country of Birth
Select applicable response from boxes provided.
3. Date of Birth
Enter patient's month/day/year of birth. Please also list any past of current alias dates of birth.
4. Vital Status
Check the appropriate box: Alive, Dead, Unknown.
5. Data of Death and the State/Territory of Death
If patient is deceased, enter date of death and state/territory of death.
6. Status
Check the appropriate diagnosis status: HIV or Stage 3 (AIDS).
7. Current Gender Identity
Enter the current gender identity of the patient: male, female, transgender male-to- female, transgender female-to-male, unknown, or additional gender identity. If the person's stated gender identity differs from the selections provided, please check the additional gender identity box and specify in the blank.
8. Ethnicity
Check the appropriate ethnicity. If no ethnicity information is available, select "Unknown." Do not choose unknown unless your search was unsuccessful.
9. Expanded Ethnicity
Enter more specific ethnicity information such as for Hispanic/Latino add "Cuban".
10. Race
Ethnicity and race are two different variables. Check the appropriate race even if information was submitted for ethnicity. Select more than one race if applicable. If no race information is

available, select “Unknown.”

11. Expanded Race
Enter more specific race information for greater detail as appropriate.

IV. RESIDENCE AT DIAGNOSIS

1. Residence at Diagnosis Address Type
Select one of the address types (residence at HIV diagnosis, residence at AIDS diagnosis, check if same as current address). If the patient’s residence at HIV diagnosis and AIDS diagnosis is the same, you may check both.

V. FACILITY AT DIAGNOSIS

1. Facility at Diagnosis
   - Enter the facility where the patient first had blood drawn and was given a diagnosis of HIV infection.
   - Enter the facility where the patient’s AIDS-defining clinical condition was first diagnosed or a CD4 count below 200 is documented. The CD4 percentage of less than 14% is no longer used to classify infections as Stage 3 (AIDS), unless a CD4 count is not available.

2. Diagnosis Type
Enter the diagnosis type that corresponds to the facility of diagnosis being reported.

3. Facility Information
Enter name of the facility, phone number, complete address and provider name.

4. Facility Type
Select the appropriate facility type. If the facility type is not listed, select “Other” and specify.

VI. PATIENT HISTORY

This data yields information about how patients may have acquired their infections.

- Patient history information can be locate in the history and physical section of the medical chart, the discharge summary, social service notes, counseling and testing notes, and STD diagnosis notes.
- If there is no information for a specific risk factor, please check “unknown” rather than leaving it blank. Blanks indicate you did not look for this information.

1. Sex with Male
Some examples of information from the medical record, which would strongly indicate sex with a male, are:

For male patient: Married to or divorced from a male; rectal gonorrhea

For female patient: Married to or divorced from a male; Boyfriend referenced in the medical record; Living with a male partner; History of pregnancy.

2. Sex with Female
   Some examples of information from the medical record, which would strongly indicate sex with a female, are:

   For male patient: Married to or divorced from a female; has a biological child

   For female patient: Married to or divorced from a female.

3. Injected Non-Prescription Drug Use (IDU)
   Check appropriate response. History of injected non-prescription drugs might have occurred at any time in the past.

4. Heterosexual Relations with Any of the Following

   - Contact with intravenous/injection drug user
     - Select applicable response and applies only to female cases.

   - Contact with a bisexual male
     - Select applicable response.

   - Contact with a person with AIDS or documented HIV infection, risk not specified
     - Select applicable response.

   - Contact with a transplant recipient with documented HIV
     - Select applicable response.

   - Contact with transfusion recipient with documented
     - Select applicable response.

5. Has the patient:
   - Received clotting factor for hemophilia/coagulation disorder
     "Coagulation disorder" or "hemophilia" refers only to a disorder of a clotting factor; factors are any of the circulating proteins named Factor I through Factor XII. These disorders include Hemophilia A and Von Willebrand's disease (Factor VIII disorders) and Hemophilia B (a Factor IX disorder).

     If "Yes" specify the clotting factor and enter date received. Enter date in *mm/dd/yyyy* format.
     If only the partner received a transfusion of platelets, other blood cells, or plasma, then select "No."

   - Received transfusion of blood/blood components (non-clotting)
     "Blood" is defined as a circulating tissue composed of a fluid portion (plasma) with suspended formed elements (red blood cells, white blood cells, platelets). Blood components" that can be transfused include erythrocytes, leukocytes, platelets, and plasma. If "Yes," specify month, day, and year of first and last transfusions before occurrence of patient's HIV diagnosis.

- Other documented risk (specify)
  If the risk for the patient is not listed, please include it here.

VII. LABORATORY DATA

1. Collection Date refers to the date when the specimen was collected or drawn.
   If search for either or both of these data was unsuccessful, then enter ".." for unknown day, month, or year of COLLECTION DATE, e.g., "06/../09."

   In the absence of laboratory tests, record HIV, stage 1, 2 or stage 3 (AIDS) diagnostic evidence documented in the chart by a physician.

2. HIV Antibody Tests (non-type differentiating)
   Assuming active case finding, review patient's chart and laboratory reports for the earliest date of documented HIV positivity, "Indeterminate" refers to indeterminate HIV antibody test results. Enter results and collection dates for first positive HIV antibody tests. The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate. Check the Rapid Test box if the test is rapid.

   - HIV-1 EIA, HIV-1/2 EIA, HIV-1/2 Ag/Ab, HIV-1 WB, HIV-1 IFA, HIV-2 EIA, HIV-2 WB, Other (specify test)
     - Enter result and collection date of each test.
     - "Positive EIA" means repeatedly reactive tests on a single sample.
     - If tests indicate HIV-1 or HIV-2 results separately, please specify the results as given in the laboratory report.

3. HIV Antibody Tests (Type Differentiating-Multispot, Geenius)
   - Assuming active case finding, review patient's chart and laboratory reports for the earliest date of documented HIV positivity.
   - Enter results and collection dates for first positive HIV antibody tests. The possible results are: HIV-1, HIV-2, Both (undifferentiated), or Neither (negative)

4. HIV Detection Tests (Qualitative)
   - All varieties of these tests establish the presence of the pathogen HIV. By contrast, HIV tests such as the EIA or WB establish the presence of HIV antibodies—our immune system's response to the pathogen.
   - Select applicable response corresponding to earliest positive detection test.
   - The possible results are: Positive/Reactive, Negative/Nonreactive, or Indeterminate.

   - HIV-1 RNA/DNA NAAT, HIV-1P24 ANTIGEN, HIV-1 CULTURE, HIV-2 RNA/DNA NAAT, HIV-2 CULTURE
   - Enter result and collection date of earliest test by culture.

5. HIV Detection Tests (Quantitative Viral Load)
   The viral load detects and quantifies the level of HIV-1 RNA in the bloodstream and is used to monitor disease progression and therapy. It is not meant to be a diagnostic test; however, a detectable level of virus in the blood confirms infection for surveillance purposes.

Enter both the earliest and most recent viral load tests. Include date of collection. Log results are no longer collected. If the lab report also includes "Detectable" or "Undetectable" result, check the appropriate box.

- HIV-1 RNA/DNA NAAT, RT-PCR, bDNA, other specify test

6. Immunological Tests (CD4 count and percentage)
   Record both CD4 count and percentage when available. Enter specimen collection date to the reported CD4 test result.

   Record the CD4 cell count and percent closest to the current diagnostic status. HIV or Stage 3 (AIDS) as well as the first CD4 count/percent less than 200/ul or less than 14% of total lymphocytes. The CD4 percentage of less than 14% of total lymphocytes is no longer used to classify infections as Stage 3 (AIDS), unless a CD4

7. Did documented laboratory test results meet approved HIV diagnostic algorithm?
   - With the most recently adopted HIV screening algorithms, eHARS will not consider two positive EIA tests as meeting case definition even though that test combination is valid to make a case. Checking "Yes" confirms that the right combination of tests is present to make a case. If "Yes" is not selected but all the proper tests are reported, eHARS will not see this patient as a confirmed case. It should only be used in the absence of a +WB, high viral load or other tests types that would meet the case definition and in the absence of a physician's documentation of diagnosis.

   - Select applicable response, enter "Yes", "No" or "Unknown."

   - Provide the date of the specimen collection date if known or the earliest positive test for this algorithm.

8. If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?
   - Select applicable response. If laboratory evidence of an HIV test is unavailable in the patient's medical or other record and written documentation of laboratory evidence of HIV infection consistent with the HIV case definition is noted by the physician, enter "Yes"; otherwise enter "No" or "Unknown."

   - Provide date of documentation by physician
     If antibody tests are not available in chart, enter date of the note in which the physician documents the patient's HIV infection. Do not record earlier date stated by the patient or the date that the physician says in the note. For example, if a health care provider writes a note in a medical chart on 4/10/2010 stating the patient had positive HIV EIA and WB the previous month. You would record 4/10/2010 as the date of documentation by the physician.

VIII. CLINICAL

1. Clinical
   For stage 3 (AIDS) reports, select the name of the opportunistic illness.

Select all that apply and enter diagnosis dates (mm/dd/yyyy).

2. Other (specify)
   This field is available for any other AIDS related opportunistic infections you may discover that are not listed above:

   - Candidiasis, bronchi, trachea, or lungs
   - Carcinoma, invasive cervical
   - Coccidioidomycosis, disseminated or extrapulmonary
   - Cryptococcosis, extrapulmonary
   - Cryptosporidiosis, chronic intestinal (>1 month duration) Cytomegalovirus, retinitis (with loss of vision)
   - HIV encephalopathy
   - Histoplasmosis, disseminated or extrapulmonary
   - Isosporiasis, chronic intestinal (>1 month duration)
   - Lymphoma, Burkitt's (or equivalent term)
   - Lymphoma, immunoblastic (or equivalent term)
   - Lymphyoma, primary in brain
   - Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
   - M. tuberculiosis, pulmonary*
   - M. tuberculosis, disseminated or extrapulmonary*
   - Mycobacterium, or other species or unidentified species, disseminated or extrapulmonary
   - Pneumonia, recurrent in 12-month period
   - Progressive multifocal leukoencephalopathy
   - Salmonella septicemia, recurrent
   - Toxoplasmosis of brain
   - Wasting syndrome, due to HIV

   *RVCT case number can be put in Section II, Patient Identification, as an ID number.

IX. TREATMENT/SERVICES REFERRALS

Check the appropriate responses.

1. Has This Patient Been Informed of His/Her HIV Infection?
   - Select applicable response.
   - If notification is not documented, select "Unknown"

2. Patient's Medical Treatment is Primarily Reimbursed By
   - Select applicable response.

3. For Female Patient
   - Is This Patient Currently Pregnant?
     - Select applicable response. Response is dependent on which date was selected for populating the field "Date Form Completed." If patient was pregnant on that date, select "Yes."

4. Has This Patient Delivered Live Born Infants?
   - Select applicable response.
   - If “Yes”, provide birth information for the most recent birth.

5. For Children of Patient

   - Child’s Name
     - Enter name of child.

   - Child’s Soundex
     - Retrieve soundex from the HIV registry (database) and enter here if child’s name was previously entered in your database and a Stateno exists.
     - If child’s name has not been entered yet, enter name and date of birth information.

     Child’s Date of Birth
     - Enter child’s month, day, and year of birth. Enter date in mm/dd/yyyy format.
     - Child to whom field refers is from the most recent birth.

     Child’s Coded ID
     - Enter any additional patient’s ID type (such as Social Security Number) and the number of the other ID.

     Child’s STATENO
     - To be completed by local health department personnel.
     - This number is typically assigned by local health department personnel if the child is known to have received a diagnosis of HIV (all stages).

6. Hospital of Birth
   - Enter the name, street address, phone number, city, county, and state of the hospital where the child described above was born in the provided fields.
   - If the child was born at home, enter “home birth.”

X. HIV TESTING AND ANTIRETROVIRAL USE HISTORY (TTH)

Enter patient-reported answers to past testing behaviors and the dates of these tests as reported by the patient. Medical staff can complete this section using information found in the medical record. If patient ever received antiretroviral medication (ARV) to treat or prevent HIV or Hepatitis B, enter at least one ARV name, date of first use and date of last use (if stopped) or most recent use (if still using ARV), if known. This information will be used in the calculation of HIV incidence rates (rates of recent infection). Unlike other sections on the ACRF, patient self-reported information is accepted for all answers.

- Main Source of Testing and Treatment History Information
  Check only one source, the main source from which the information in this section was obtained.

  - ”**Patient Interview”** is selected only if the patient was directly asked a series of

questions from this or another structured TTH form. Interviewer should be trained on the proper collection of TTH data.

- ”**Medical Record Review**” indicates that this information was obtained through abstraction of medical charts, electronic medical records, or databases. Information may also come from a database of HIV test results or pharmacy records.
- **”Provider Report”** indicates this form is filled out by a health care provider.
- **”NHM&E/PEMS”** indicates that data were abstracted from the National HIV Monitoring and Evaluation (NHM&E) and the Program Evaluation and Monitoring System (PEMS) project forms or databases.
- **“‘Other**” indicates that information came from a source other than those listed above.

- Date Patient Reported Information
  - The appropriate date to enter depends on the MAIN SOURCE OF TTH INFORMATION: If there is a structured patient interview, enter the date of the interview. For a medical record review, enter the date of the last patient encounter that contributed to the TTH information collected. If only a laboratory report was accessed, enter the date of receipt of the laboratory results. If there was no patient encounter or laboratory test receipt date, then enter the date the medical record review was performed. If the ACRF is completed by a health care provider, enter the date of the last patient encounter when the most recent TTH information was obtained from the patient. If provider’s information only came from another data source, such as a laboratory report, enter the date of receipt of the information. If there are no such dates, enter the date the ACRF was completed. If there are no data available from the above sources, enter the date the ACRF was completed.

- Ever Had a Previous Positive HIV Test?
  - The purpose of this question is to report if any positive HIV test occurred before the known date of HIV diagnosis, for example a test performed in another state or country or an anonymous test. If there is a date of earlier positive HIV test, enter it in the next field on the form. Self-reported information is appropriate. Do not count indeterminate tests. ”Yes” indicates evidence that the person had a previous positive HIV test, including patient self-report. ”No” indicates sufficient evidence that there was no previous positive HIV test. Do not answer ‘no’ if there is a lack of evidence either way about previous tests. ”Refused” indicates patient refused to answer the question or facility refused to permit medical record review. ”Don’t know” indicates that the patient, chart reviewer, or provider has no knowledge whether or not there was a previous positive HIV test, after searching for the information or asking the patient. The field should be left blank if the medical record was not searched or the question was not asked

- Date of First Positive HIV Test
  - Record the date of the earliest known positive HIV test, including patient self-reported dates. It is acceptable to enter an estimated or incomplete date, as long as it contains a year. If it is known that there were no previous positive HIV tests, enter the date of the first positive HIV test (i.e., the collection date of the diagnostic HIV test) and answer ”no” to the previous question (“Ever had previous positive HIV test”).If you do not know the date of HIV diagnosis, enter the earliest known positive HIV test.

- Ever Had a Negative HIV Test?
    - Because this question is used to classify persons as new or previous testers for incidence estimation, it is important to not make assumptions. The mere absence of information about previous tests in a medical record should not be recorded as ”no,“ since tests can occur in other venues. Self-reported information is accepted. Ignore indeterminate tests. “Yes” indicates there is knowledge of a previous negative HIV test, either self- reported or confirmed by a laboratory report. If the answer is ”yes,“ enter the date in the next field on the form, if it is available. ”No” indicates there is evidence that the person never had a negative HIV test. For example, the person states they never have been tested before. Do not enter ”no” if there is simply no evidence either way about a previous HIV test. “‘Refused” indicates patient refused to answer the question or facility refused to permit medical record review. ”Don’t Know/Unknown” indicates there is insufficient evidence supporting or denying the occurrence of a negative HIV test, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

- Date of Last Negative HIV Test?
    - This is the most important information for incidence estimation. This date is used to categorize persons as repeat testers and to estimate frequency of testing. Self-reported information is accepted. Documented negative HIV test dates also should be entered in the Laboratory Data section under date of last documented negative HIV test, along with the test type. Enter the date of the last known negative HIV test, either self-reported or confirmed by a laboratory test. The person may have had a more recent negative test at another facility, unknown to the provider or chart abstractor, but it is more important to enter any known date than to leave it blank. Incomplete dates are acceptable if the year is included.

- Number of Negative HIV Tests Within 24 Months Before First Positive Test
    - Count the number of negative HIV tests in the 24 months before the first positive HIV test. Do not count indeterminate or positive HIV tests or those with unknown results. Enter ”0” if it is known that the patient has never been tested for HIV before or never had a negative test. Check ”Refused” if the patient refused to answer the question or facility refused to permit medical record review. Check ”Don’t Know/Unknown” if the patient or person completing the form does not know or if the results of a test are unknown, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

- Ever Taken Any Antiretrovirals (ARVs)?
    - This field indicates whether the patient has ever taken any ARV medication to prevent or treat HIV or hepatitis, particularly before HIV diagnosis. This is important because ARV use may affect STARHS results. Most patients have not taken ARVs before the date of HIV diagnosis, but some have taken them for hepatitis or for HIV pre-exposure prophylaxis. This question is also used to determine specimen eligibility for VARHS system that monitors the distribution of HIV-1 mutations associated with HIV drug resistance and subtypes among persons with newly diagnosed HIV infection. ”Yes” indicates there is evidence that the person has taken ARVs, including self- reported. If ”Yes”, it is important to enter the dates when use began and, if

appropriate, ended. ”No” indicates there is evidence that the patient has never taken ARVs. ”Refused”’ indicates that the patient refused to answer the question or facility refused to permit medical record review. ”Don’t Know/Unknown” should be used when the person completing the form does not know whether or not the patient has ever taken ARVs, after searching for the information or asking the patient. Leave the question blank if there was no attempt to find the information.

- If Yes, What ARV Medications?
    - This field is used for verification that the medication taken was actually an antiretroviral medication. It is not necessary to list all medications, only one. However, more can be listed if there is space. Enter “unspecified” if an ARV was taken but the name is not known.

- Dates ARVs First Taken
    - Enter the earliest date that the patient ever took ARVs, even if ARV use was sporadic. If the first time ARVs were taken occurred after HIV diagnosis, it is very important to enter a date, even an estimated date, later than the date of HIV diagnosis.

- Dates ARVs Last Taken
    - Enter the last known date of ARV use. For patients currently on ARVs, record the date of the last prescription or known usage. If the information is collected during a patient interview, the date would be the interview date. If the information was collected as part of a medical record review, record the date of the last prescription or date of the last physician’s note.

XI. Duplicate Review

- STATUS
    - This section can be used for information related to duplicate review. If a case is determined to be a duplicate, it should be determined if the duplicate is ”Same As” or ”Different Than” the other case.
- STATE
    - If a duplicate is found, enter the state here.
- STATENO
    - If a duplicate case was found, the STATENO of the duplicate case must go here.

XII. Comments and Local/Optional Fields

- This section can be used for information not requested on the form or for information requested but where there might not be room in the space provided.

Appendix 1

State of California - Health and Human Services Agency — California Department of Public Health - Office of AIDS

ADULT HIV/AIDS CASE REPORT FORM
(Patients ≥ 13 Years of Age at Time of Diagnosis)

I. Health Department Use Only *(See Appendix 1.0 for Further Details) (Record All Dates as mm/dd/yyyy)* ***Shaded Fields are Required. All Others are Optional.***

Name of Person Completing Form:	Person's Phone Number: ( )	STATENO:	CITYNO:
Date Form Completed: ___/___/___	Reporting Health Department - City/County:	Document Source:	
Report Status: ☐ 1- New ☐ 2- Update	Physician's Name:	Physician's Phone Number: ( )	Hospital/Facility Name:
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Surveillance Method: ☐ Active ☐ Passive ☐ Follow Up ☐ Reabstraction ☐ Unknown	Report Medium: ☐ 1- Field Visit ☐ 2- Mailed ☐ 3- Phone ☐ 4- Electronic Transfer ☐ 5- CD/Disk	

II. Patient Identification

Patient Last Name:	Middle Name:	First Name:	
Alternate Name Type *(e.g. Alias, Married, etc.)*:	Last Name:	Middle Name:	First Name:
Address Type: ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary			
Current Street Address:	City:	County:	
State/Country:	ZIP Code:	Phone Number: ( )	Social Security Number:	Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:	

III. Patient Demographics *(See Appendix 2.0 for Further Details) (Record All Dates as mm/dd/yyyy)*

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other/U.S. Dependency *(please specify)*:	Date of Birth: ___/___/___
Alias Date of Birth: ___/___/___	Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: ___/___/___	State of Death:	Status: ☐ HIV ☐ AIDS
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male-to-Female (MTF) ☐ Transgender: Female-to-Male (FTM) ☐ Unknown ☐ Other Gender Identity *(specify)*:			Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Chinese ☐ Vietnamese ☐ Japanese ☐ Asian Indian ☐ Filipino ☐ Laotian ☐ Korean ☐ Cambodian ☐ Pacific Islander ☐ Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)*:
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity:		
Expanded Race:			

IV. Residence at Diagnosis *(See Appendix 3.0 for Further Details - Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)*

Address Type *(check all that apply)*: ☐ Residence at HIV Diagnosis ☐ Residence at AIDS Diagnosis ☐ Check if SAME as Current Address

	Street Address:	City:	County:	State/Country:	ZIP Code:
Address of Residence at HIV Diagnosis					
Address of Residence at AIDS Diagnosis					

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V. Facility at Diagnosis *(See Appendix 4.0 for Further Details - Add Additional Facilities in Comments and Local/Optional Fields Section)* **STATENO:**

Diagnosis Type *(check all that apply to facility)*: ☐ HIV Diagnosis ☐ AIDS Diagnosis ☐ Check if SAME as Facility Providing Information

Facility Name:	Phone Number: ( )	Street Address:	City:

County:	State/Country:	ZIP Code:	Provider Name:

Facility Type:

Inpatient: ☐ Hospital ☐ Other *(specify)*: _____

Outpatient: ☐ Private Physician ☐ Adult HIV Clinic ☐ Other *(specify)*: _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other *(specify)*: _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other *(specify)*: _____

VI. Patient History *(See Appendix 5.0 for Further Details - Respond to All Questions)* ☐ **Pediatric Risk** *(Please Enter In Comments and Local/Optional Fields Section)*

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with a male: ☐ Yes ☐ No ☐ Unknown Sex with a female: ☐ Yes ☐ No ☐ Unknown Injected non-prescription drugs: ☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL relations with any of the following:	**Has the patient:**
Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown	Received clotting factor for hemophilia/coagulation disorder: ☐ Yes ☐ No ☐ Unknown
Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown	Received transfusion of blood/blood components *(non-clotting)*: ☐ Yes ☐ No ☐ Unknown
Contact with a person with AIDS or documented HIV infection, risk not specified: ☐ Yes ☐ No ☐ Unknown	Other documented risk: *(If yes, specify)*: ☐ Yes ☐ No ☐ Unknown
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	
Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	

VII. Laboratory Data *(Record All Dates as mm/dd/yyyy) (See Instructions for Details)*

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]

TEST 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test)*: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid)*: ☐ **Collection Date:** ___/___/_____
Manufacturer: _____

TEST 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test)*: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid)*: ☐ **Collection Date:** ___/___/_____
Manufacturer: _____

TEST 3: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test)*: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid)*: ☐ **Collection Date:** ___/___/_____
Manufacturer: _____

HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]

TEST: ☐ HIV-1/2 Differentiating *(e.g. Multispot)*

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both *(undifferentiated)* ☐ Neither *(negative)* **Collection Date:** ___/___/_____

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Adult HIV/AIDS Case Report Form (ACRF) Instructions

VII. Laboratory Data *(continued)* *(Record All Dates as mm/dd/yyyy)* **STATENO:**

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

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

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** ___/___/_____

HIV Detection Tests (Quantitative Viral Load) ***Note: Include earliest test after diagnosis***

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** ___/___/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** ___/___/_____

Immunologic Tests (CD4 Count and Percentage)

CD4 at or closest to current diagnosis 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:** ___/___/_____

Other CD4 result <200 cells/µL or <14%: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date:** ___/___/_____

Documentation of Tests *(Complete 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? ☐ 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? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of documentation by physician: ___/___/_____

VIII. Clinical *(Check Boxes Where Applicable)* *(Record All Dates as mm/dd/yyyy)*

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

IX. Treatment/Services Referrals *(Record All Dates as mm/dd/yyyy)*

Has This Patient Been Informed of His/Her HIV Infection? ☐ Yes ☐ No ☐ Unknown

Patient's Medical Treatment is Primarily Reimbursed by:

☐ 1- Medicaid ☐ 2- Private Insurance/HMO ☐ 3- No Coverage ☐ 4- Other Public Funding ☐ 9- Unknown

For Female Patient:

Is This Patient Currently Pregnant? ☐ Yes ☐ No ☐ Unknown

Has This Patient Delivered Live-Born Infants? ☐ Yes ☐ No ☐ Unknown

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IX. Treatment/Services Referrals *(continued)* *(Record All Dates as mm/dd/yyyy)* **STATENO:**

For Children of Patient: *(Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)*

Child's Name:	Child's Soundex:	Child's Date of Birth: ___/___/___
Child's Coded ID:	Child's STATENO:	

Hospital of Birth: *(If Child Was Born at Home, Enter "Home Birth" for Hospital Name)*

Hospital Name:	Phone Number: ( )
Street Address:	City:

County:	State/Country:	ZIP Code:

X. HIV Testing and Antiretroviral Use History (TTH) *(Record All Dates as mm/dd/yyyy)* *(Required Sections for New Case Report Only)*

Main Source of Testing and Treatment History Information *(select one)*: ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other *(specify)*:	Date Patient Reported Information: ___/___/___

Ever Had a Positive HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of First Positive HIV Test: ___/___/___	Ever Had a Negative HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of Last Negative HIV Test: *(If date is from a lab test with test type, enter in Laboratory Data Section.)* ___/___/___

Number of Negative HIV Tests Within 24 Months Before First Positive Test *(#)*: _____ ☐ Refused ☐ Don't Know/Unknown

Ever Taken Any Antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, What ARV Medications?

Date ARVs First Taken: ___/___/___	Date ARVs Last Taken *(mm/dd/yyyy)*: ___/___/___

XI. Duplicate Review

Status *(check one)*: ☐ Same As ☐ Different Than ☐ Pending	State Name:	STATENO:

XII. Comments and Local/Optional Fields

LOCAL HEALTH DEPARTMENTS:
SUBMIT COMPLETED FORM TO THE OFFICE OF AIDS PER YOUR CONTRACT'S SCOPE OF WORK, EXHIBIT A, PART D, OBJECTIVE 2.

PROVIDERS:
SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
Local Health Department HIV/AIDS contact list is available at: www.cdph.ca.gov/programs/AIDS/pages/tOAHIVRptgSP.aspx

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Appendix 2
Document Source Codes for HIV Reporting

Document Source Code Labels	
A01 = Inpatient Record	A01.01 = IP/Acute Care Facility A01.01.01 = IP/ACF/Infection Control Practitioner A01.01.02 = IP/ACF/OBGYN records A01.01.02.01 = IP/ACF/OBGYN/Prenatal Care records A01.01.02.02 = IP/ACF/OBGYN/Labor & Delivery records A01.01.03 = IP/ACF/Pediatric records A01.01.04 = IP/ACF/Birth records A01.01.05 = IP/ACF/All other records A01.02 = IP/Veterans Administration Hospital A01.02.01 = IP/VA/Infection Control Practitioner A01.02.02 = IP/VA/All other records A01.03 = IP/Military Hospital A01.03.01 = IP/ MH/Infection Control Practitioner A01.03.02 = IP/ MH/OBGYN records A01.03.02.01 = IP/ MH/OBGYN/Prenatal Care records A01.03.02.02 = IP/ MH/OBGYN/Labor & Delivery records A01.03.03= IP/ MH/Pediatric records A01.03.04 = IP/ MH/All other records A01.04 = IP/Long Term Care Facility A01.04.01 = IP/ LTCF/Nursing Home A01.04.02 = IP/ LTCF/Rehabilitation Center A01.04.03 = IP/ LTCF/Drug Treatment Program A01.05 = IP/Hospice

A02 = Outpatient Record	A02.01 = OP/HMO A02.01.01 = OP/HMO/Hospital Associated Outpatient clinic A02.01.02 = OP/HMO/Non-Hospital Associated Outpatient clinic A02.02 =OP/ VA Outpatient clinic A02.03 = OP/Private Physician A02.03.01 = OP/PP/Hospital Associated Outpatient clinic A02.03.02 = OP/PP/Non-Hospital Associated Outpatient clinic A02.04 = OP/Adult HIV Clinic A02.04.01 = OP/Adult HIV Clinic/Hospital Associated Outpatient clinic A02.04.02 = OP/Adult HIV Clinic/Non-Hospital Associated Outpatient clinic A02.05 = OP/Infectious Disease clinic A02.05.01 = OP/ IDC/Hospital Associated Outpatient clinic A02.05.02 = OP/ IDC/Non-Hospital Associated Outpatient clinic A02.06 = OP/County Health Department clinic A02.07 = OP/Maternal HIV Clinic A02.07.01 = OP/Maternal HIV Clinic/Hospital Associated Outpatient clinic A02.07.02 = OP/Maternal HIV Clinic/Non-Hospital Associated Outpatient clinic A02.08 = OP/Prenatal Clinic or Records A02.08.01 = OP/ PRC/Hospital Associated Outpatient clinic A02.08.02 = OP/ PRC/Non-Hospital Associated Outpatient clinic A02.09 = OP/Pediatric HIV Clinic A02.09.01 = OP/Pediatric HIV Clinic/Hospital Associated Outpatient clinic A02.09.02 = OP/Pediatric HIV Clinic/Non-Hospital Associated Outpatient clinic A02.10 = OP/Obstetrics and Gynecology A02.10.01 = OP/OBGYN/Hospital Associated Outpatient clinic A02.10.02 = OP/OBGYN/Non-Hospital Associated Outpatient clinic A02.11 = OP/Pediatric clinic A02.11.01 = OP/PC/Hospital Associated Outpatient clinic A02.11.02 = OP/PC/Non-Hospital Associated Outpatient clinic A02.12 = OP/TB clinic A02.12.01 = OP/TB Clinic/Hospital Associated Outpatient clinic A02.12.02 = OP/TB Clinic/Non-Hospital Associated Outpatient clinic A02.14 = OP/Indian Health Service clinic A02.14.01 = OP/IHS/Hospital Associated Outpatient clinic A02.15 = OP/Early Intervention Nurse A02.15.01 = OP/ EIN/Hospital Associated Outpatient clinic A02.15.02 = OP/ EIN/Non-Hospital Associated Outpatient clinic

A02 = Outpatient Record Continued	A02.16 = OP/Visiting Nurse Service A02.16.01 = OP/ VNS/Hospital Associated A02.16.02 = OP/ VNS/Non-Hospital Associated A02.17 = OP/Hemophilia Treatment Center A02.17.01 = OP/ HTC/Hospital Associated Outpatient clinic A02.17.02 = OP/ HTC/Non-Hospital Associated Outpatient clinic A02.18 = OP/Hospice A02.18.01 = OP/Hospice/Hospital Associated Outpatient clinic A02.18.02 = OP/Hospice/Non-Hospital Associated Outpatient clinic A02.19 = OP/Drug Treatment Center A02.19.01 = OP/ DTC/Hospital Associated Outpatient clinic A02.19.02 = OP/ DTC/Non-Hospital Associated Outpatient clinic A02.20 = OP/Rehabilitation Center A02.20.01 = OP/ RC/Hospital Associated Outpatient clinic A02.20.02 = OP/ RC/Non-Hospital Associated Outpatient clinic A02.25 = OP/Other Clinic A02.25.01 = OP/Other/Hospital Associated Outpatient clinic A02.25.02 = OP/Other/Non-Hospital Associated Outpatient clinic
A03 = Emergency Room	A03 = Emergency room record not resulting in admission
A04 = Screening, Diagnosis and Referral Agencies	A04.01 = SDRA/Blood Bank A04.02 = SDRA/Drug Treatment Clinic or Program A04.03 = SDRA/Family Planning Clinic A04.04 = SDRA/HIV Case Management Agency A04.05 = SDRA/HIV Counseling and Testing Site A04.06 = SDRA/Immigration A04.07 = SDRA/Insurance report A04.08 = SDRA/Job Corps A04.09 = SDRA/Military A04.10 = SDRA/Partner Referral and Counseling Service A04.11 = SDRA/STD Clinic A04.12 = SDRA/Public Health Notes
A05 = Laboratories	A05.01 = Laboratory/Hospital laboratory A05.02 = Laboratory/State laboratory A05.03 = Laboratory/Private laboratory A05.03.01 = Laboratory/Private/Reference laboratory A05.03.02 = Laboratory/Private/Other laboratory

A06 = Other Database	A06.01= Other Database/AIDS Drug Assistance Program (ADAP) A06.02 = Other Database/ASD A06.03 = Other Database/Birth Certificate A06.04 = Other Database/Birth Defects registry A06.05 = Other Database/Cancer registry A06.06 = Other Database/Database provided by coroner not associated with inpatient facility A06.07 = Other Database/Death Certificate A06.08 = Other Database/EHRAP A06.09 = Other Database/EPS A06.10 = Other Database/HARS A06.11 = Other Database/Health department records A06.12 = Other Database/Hepatitis registry A06.13 = Other Database/Hospital billing summary or discharge records A06.14 = Other Database/HRSA HIV CARE A06.15 = Other Database/Immunization registry A06.16 = Other Database/Medicaid records A06.17 = Other Database/National Death Index (NDI) Search A06.18 = Other Database/Out of State Reports A06.19 = Other Database/Prison, Jail or Other Correctional Facility A06.20 = Other Database/PSD A06.21 = Other Database/State Disease registry A06.22 = Other Database/SHAS A06.23 = Other Database/SHDC A06.24 = Other Database/STD registry A06.25 = Other Database/Tuberculosis registry A06.27 = Other Database/Vital Statistics (state/local) A06.28 = Other Database/HARS NDI A06.29 = Other Database/RIDR A06.30 = Other Database/SSDMF or SSDI A06.34 = Other Database/MMP A06.34.01 = Other Database/MMP/Medical Record Abstraction A06.34.02 = Other Database/MMP/Patient Interview A06.35 = Other Database/FIMR A06.35.01 = Other Database/FIMR/Medical Record Abstraction A06.35.02 = Other Database/FIMR/Patient Interview A06.50 = Other DB/Other database or report
A07 = Other Facility Records	A07.01 = Other Facility Records/Prison, jail or other correctional facility A07.02 = Other Facility Records/Coroner not associated with inpatient facility
A10 = Other Source	A10.01 = COPHI Investigation A10.02 = Patient Interview