

**INSTRUCTIONS FOR COMPLETION OF THE MICHIGAN ADULT HIV/AIDS  
CASE REPORT FORM  
May 2010**

The yellow HIV/AIDS case report form (CRF) is Michigan's version of the CDC 50.42A and, as of the date of its release, replaces all prior HIV and AIDS case report forms for age 13 and over (A separate white form CDC 50.42B is used for reporting HIV/AIDS in persons under age 13.) Instructions for each section of the form are described below. The attached form may be photocopied or downloaded from [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd). More copies of the form may be obtained through your local health department or by contacting the MDCH HIV, STD & Bloodborne Infections Surveillance Section at either 313-876-0353 or 517-335-8165.

All patients with evidence of HIV infection, including AIDS, should be reported within 7 days of diagnosis, including a diagnosis made by a physician based on history and symptoms. AIDS cases () include all patients with a history of HIV infection who also have documented CD4 levels under 200 cells/microliter or a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14%, or any of the AIDS indicator diseases listed in Section X of the form. See December 5, 2008 / 57(RR10);1-8 for complete HIV and AIDS definitions. **All required information has been emphasized below in bold print.**

Completed forms should be mailed to the local health department (LHD) where the patient resides, unless arrangements have been made to first send them to MDCH or the LHD where the facility is located. If this is not possible, mail forms to the LHD where your facility is located, or to HIV/AIDS Surveillance at the Michigan Department of Community Health located at Herman Kiefer Health Complex, Room 211B, 1151 Taylor, Detroit, MI 48202. When mailing the form, please address the envelope to the AIDS Coordinator or other designated local contact. To protect patient confidentiality, please make sure you either use two envelopes, a security envelope, or wrap a sheet of plain white paper around the case report form (so no confidential information can be seen through the envelope). Finally, mark the envelope "Confidential" and "To Be Opened By Addressee Only."

**NOTE:** For all instances on the case report form answers of "Y" or "yes" will be interpreted as if the event in questions has occurred. Answers of "N" or "no" will be interpreted as if the event in question did NOT occur. Answers of "Unk" or "unknown" will be interpreted as if there was no data in the source used to complete the CRF to allow a determination of "yes" or "no" to be made. Finally, blank or missing answers will be interpreted as if no source was examined to allow a determination of "yes" or "no" to be made.

**SIDE 1**

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**SECTION I.  
Health  
Department  
Use Only**

Please leave this section blank for state health department use.

**SECTION II.  
Patient  
Identifier  
Information**

**For confidential testers, enter the patient's full name, complete current address, phone number and social security number.** If available, record maiden names, aliases and/or "Unique Identifier Numbers" (UIN), or City-County Numbers if used.

**SECTION III.  
Form  
Information**

**Please provide the date the CRF was completed and the name and phone number for the individual who could be reached to answer questions concerning the information provided on the CRF.** This person can be a physician, nurse, or any confidentiality-trained staff member with knowledge to interpret and access the patient's medical information.

**SECTION IV.  
Current  
Provider  
Information**

**Please provide the physician, facility and phone where the patient is currently receiving HIV care.** This may or may not be the same physician or facility that provided HIV testing. If possible, provide the medical record number used for the patient at this facility.

**SECTION V.  
Demographics**

**Diagnostic Status**

**Check the appropriate box under Diagnostic Status whether you are reporting "Adult HIV" or "Adult AIDS"** (the patient meets the 2008 CDC AIDS definition; see introduction to these instructions for the definition of AIDS). All information that follows should correspond to the diagnostic status specified (HIV or AIDS).

Please indicate if a care provider believes that this patient is recently (acutely) infected with HIV or is experiencing acute retroviral syndrome. No documentation is required.

**Sex at Birth**

**Please indicate the biological sex the patient was assigned at birth.**

**Current Gender**

Please indicate the gender to which the patient most closely identifies at time of diagnosis (this may or may not be different than the sex the patient was assigned at birth) and if the patient identifies as a transgender female (Trans to Female) or as a transgender male (Trans to Male). Transgender is an umbrella term used for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. For the purposes of HIV case surveillance this term includes transgender people regardless of whether they have altered their bodies hormonally and/or surgically.

**Date of Birth**

**Please indicate with complete 4-digit year. Please also list any past or current alias dates of birth.**

**County of Birth**

Check correct box and include specific country if other than US or US Dependencies/Possessions.

**Vital Status**

Check correct box

**Death Date**

Complete, if known

**Marital Status**

Circle correct status

**Ethnicity**

**Ethnicity and race and two different variables. The appropriate box MUST be checked for each variable.**

**Race**

Ethnicity and race are two different variables. The appropriate box **MUST** be checked for each variable. If applicable, more than one race may be selected.

**Residence at Diagnosis**

If same as current residence, check box, if not, please provide full address.

**SECTION VI.  
Facility of  
Diagnosis**

Enter the name of the facility, physician and the address, city and state of the facility where the patient was first **diagnosed** (as HIV positive or as AIDS, accordingly). Facility type should also be specified with public clinics, counseling and testing sites and community based organizations written in as “other.”

**SECTION  
VII.  
HIV Testing  
and  
Treatment  
History**

**Testing and treatment history information must be completed for all HIV/AIDS reports in Michigan. Dates are very important in this section.** 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 received medication to treat or prevent HIV or Hepatitis B, enter medication names and start/end dates as applicable, if known. This information will be used in the calculation of HIV incidence rates (rates of recent infection). Also note if the patient is on PCP prophylaxis.

**SECTION  
VIII.  
Patient  
History**

**Check ALL boxes in appropriate columns.** Indicate first and last dates of any blood transfusions. Write in specific occupation if patient is, or was, a healthcare worker. If there is no information for a specific risk factor please check “unknown” rather than leaving it blank.

**SECTION IX.  
Documented  
Laboratory  
Data**

**Please document the first rapid, HIV 1/ HIV 2 EIA, HIV 1 WB, and/or HIV2 WB test, recording the test type (blood or oral fluid), result (positive, negative, or indeterminate) and collection date.**

**If a prior negative HIV antibody test is documented on a positive patient please indicate their positive test result (with type, result and collection date) and use the line “LAST DOCUMENTED NEGATIVE ANTIBODY TEST” to give the collection date of their previous negative test result.**

**Please document earliest known positive HIV detection tests with type (NAT, p24 Antigen, Qual PCR RNA, Qual PCR DNA) and collection date.**

**Please record both the earliest and most recent viral load tests and indicate the test type (1, 2, 3, or 4).**

**Please record the CD4 cell count and percent closest to the current diagnostic status (i.e., HIV or AIDS) as well as the first CD4 count/percent less than 200/ul or less than 14% of total lymphocytes. Include date of all tests.**

If laboratory documentation of a positive HIV test is unavailable in the medical record, enter the earliest date the physician documented the patient’s HIV infection.

A physician diagnosis is made by clinical and/or laboratory evaluation and should be clearly documented (e.g., in progress notes). Prescription of anti-retroviral drugs is sufficient evidence of a physician diagnosis of HIV infection.

Please indicate if the patient has received an HIV genotype testing and if possible the date and lab at which the testing was conducted.

**SECTION X.  
AIDS  
Indicator  
Diseases**

Please indicate whether the clinical record was reviewed. **For AIDS reports, check all known indicator diseases and enter dates of diagnosis. Specify whether presumptive or definitive.** (Definitive diagnoses are generally based on specific laboratory methods, while presumptive diagnoses are those made by the clinician. A complete description may be found in the MMWR supplement RR-17, Vol. 41, December 18, 1992).

**SECTION XI.  
Treatment/  
Services  
Referrals**

**Complete all partner services (AKA PCRS or contact tracing) questions. They are: "Has the patient been informed of his/her HIV infection?" and "Who will counsel the patient's partners about their HIV exposure?"** Under Michigan law, *notifying the known sex or needle-sharing partners of HIV-infected patients is an affirmative duty of the attending physician.* This responsibility may be discharged to local public health by checking the 'Local Health Dept' box.

For patients diagnosed with HIV, please check a box under HIV that corresponds to the primary method that the patient's HIV care will be reimbursed. For patients diagnosed with AIDS, please check a box under AIDS that corresponds to the primary method that the patient's AIDS care will be reimbursed.

Enter whether referrals have been made for HIV medical services and/or substance abuse treatment services.

**SECTION  
XII.  
Women Only**

For women, list all known obstetrical information as requested. **Please indicate whether the patient is currently pregnant and list their EDC or due date.** Provide birth information, if applicable, for their most recent birth: child's date of birth and address of birth hospital. Enter "home birth" if born at home and include the full name of the child.

**SECTION  
XIII.  
Comments**

Please add any additional laboratory, clinical, partner services or other relevant information here.