

Michigan Adult HIV/AIDS Confidential Case Report Form

MDCH DATE ENTERED:

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

I. HEALTH DEPT USE ONLY

Document ID	Soundex Code	Report Status	Date Rec'd at MDCH	State Number
MI00-		New Update	____/____/____	
Document Source	New Investigation	Report Medium	Surveillance Method	
A - - - - -	Y N U		A F P R U	

II. PATIENT IDENTIFIER INFORMATION – data not transmitted to CDC

Patient Name: _____ Patient Alias _____ SS#: _____
last first middle

Current Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone: () _____ - _____ City/County Patient Number or UIN if used: _____

III. FORM INFORMATION

Date form completed: ____/____/____ Person completing form: _____ Phone: () _____ - _____

IV. CURRENT PROVIDER INFORMATION

Physician: _____ Facility: _____
last first middle

City: _____ State: _____ Phone: () _____ - _____

Med Rec No: _____ Date 1st seen: ____/____/____ Date last seen: ____/____/____

V. DEMOGRAPHIC INFORMATION – complete ALL fields

Diagnostic Status: <input type="checkbox"/> Adult HIV <input type="checkbox"/> Adult AIDS	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____/____/____	Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Unk <input type="checkbox"/> Other _____	Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Death Date: ____/____/____ State/Terr of Death: _____
Marital Status: S M W D Oth Unk	Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Arabic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Race (check all that apply): <input type="checkbox"/> Black/AA <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unk <input type="checkbox"/> Other _____			
Residence at Diagnosis: <input type="checkbox"/> Same as Current Street Address: _____ City: _____ County: _____ State/Country: _____ Zip: _____					

VI. FACILITY OF DIAGNOSIS

Facility Name: _____

Physician: _____

Address: _____

City: _____

State/Country: _____

Facility Type:
 Private Physician Hospital Inpatient
 Outpatient Emergency Department
 Other: _____

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before the 1 st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
• Sex with male			
• Sex with female			
• Injected drugs			
• Received clotting factor			
HETEROsexual relations with the following:			
• Injecting Drug User (IDU)			
• Bisexual male (applies to females only)			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
Received transfusion Date 1 st : / / Date last: / /			
Received organ transplant, tissue or artificial insemination			
Worked in healthcare/clinical laboratory OCCUPATION:			
Perinatally Infected			
Other:			

VIII. HIV TESTING AND TREATMENT HISTORY

Date questions answered by patient: ____/____/____

DATE OF FIRST POSITIVE HIV TEST REPORTED BY PATIENT

Date (mo/yr): ____/____

DATE OF LAST NEGATIVE HIV TEST REPORTED BY PATIENT

Date (mo/yr): ____/____ Never had negative HIV test

PRIOR TESTS (2 Years before 1st positive)

Number of HIV tests in 2 years before first positive:
1 (first positive) + ____ (# prior tests) = ____ TOTAL

ANTIRETROVIRAL & PROPHYLAXIS TREATMENT HISTORY

Used ARV to prevent/treat HIV or HepB? Yes No

If yes, list medications:

First date of ARV use (mo/day/yr): ____/____/____
 Currently using ARV? Yes No
 If no: Last date of ARV use (mo/day/yr): ____/____/____

Has patient received PCP prophylaxis? Yes No

IX. DOCUMENTED LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (FIRST known pos. test)						
	RESULT			TEST DATE		
	Pos	Neg	Indet	Mo	Day	Yr
HIV-1 EIA						
HIV1/HIV2 EIA						
HIV1 Western Blot						
HIV2 Western Blot						
POSITIVE HIV DETECTION TEST: (EARLIEST known test)						
<input type="checkbox"/> NAT	<input type="checkbox"/> p24 Antigen					
<input type="checkbox"/> Qual PCR RNA	<input type="checkbox"/> Qual PCR DNA					
VIRAL LOAD TEST: (EARLIEST & MOST RECENT tests)						
Test Type:	COPIES/ML:		Mo	Day	Yr	
00 NASBA						
03 RT-PCR (stand)						
04 RT-PCR(ultrasen)						
05 bDNA - version 2						
06 bDNA - version 3						

IMMUNOLOGIC LAB TESTS:			
At or closest to current diagnostic status	Mo	Day	Yr
CD4 Count: _____ cells/ul (____%)			
CD4 Count: _____ cells/ul (____%)			
<i>First <200 or <14% of total lymphocytes</i>			
CD4 Count: _____ cells/ul (____%)			
CD4 Count: _____ cells/ul (____%)			
PHYSICIAN DIAGNOSIS:			
If HIV lab tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
If YES, provide date of physician documentation			Mo Day Yr
GENOTYPE TESTING:			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If YES, Date: ____ / ____ / ____			
Specify Lab Performing Test: _____			

X. AIDS INDICATOR DISEASES

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
	___/___/___		<input type="checkbox"/>
Candidiasis, bronchi, trachea, or lungs	___/___/___		<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___		<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal	___/___/___		<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___		<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___		<input type="checkbox"/>
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___		<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___		<input type="checkbox"/>
Isosporiasis, chronic intestinal	___/___/___		<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___		<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___		<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___		<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV	___/___/___		<input type="checkbox"/>

XI. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Local Health Dept <input type="checkbox"/> Physician/provider <i>MI law requires physician to notify known partners or request help from local health dept.</i>	This patient's medical treatment is primarily reimbursed by:		
	HIV	AIDS	
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid/Medicare	
<input type="checkbox"/>	<input type="checkbox"/>	Private insurance	
<input type="checkbox"/>	<input type="checkbox"/>	No coverage	
<input type="checkbox"/>	<input type="checkbox"/>	Other public funding	
<input type="checkbox"/>	<input type="checkbox"/>	Clinic trial/program	
<input type="checkbox"/>	<input type="checkbox"/>	Unknown	
	Yes	No	Unk
Is patient enrolled in a clinic/clinical trial? IF YES, name: _____			
Is patient receiving or been referred for:			
• HIV related medical services?			
• Substance Abuse treatment services?			

XII. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, physician _____	
Is patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, list EDC (due date) ____/____/____	
Has patient delivered a live-born infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, provide Grava____ Para____ & info below for most RECENT birth Date of Birth: ____/____/____ Hospital of Birth: _____ City: _____ State: _____ Zip: _____ Child's Name: _____ last first middle	

XIII. COMMENTS:
