

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

MDCH Date Entered: \_\_\_\_\_

**I. HEALTH DEPARTMENT USE ONLY**

Document ID	Soundex Code	Date Rec'd at MDCH	State Number
MI00-		____/____/____	
Document Source	Report Status	Report Medium	Surveillance Method
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**II. PATIENT IDENTIFIER INFORMATION - data not transmitted to CDC**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Maiden/Alias \_\_\_\_\_  
 Current Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ SS# \_\_\_\_\_ City/County Patient Number or UIN if used \_\_\_\_\_

**III. FORM INFORMATION**

Date Form Completed \_\_\_\_/\_\_\_\_/\_\_\_\_ Person Completing Form: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

**IV. CURRENT PROVIDER INFORMATION**

Physician Name: Last \_\_\_\_\_ First \_\_\_\_\_ Facility \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Med Rec No \_\_\_\_\_

**V. DEMOGRAPHIC INFORMATION - COMPLETE ALL FIELDS**

<b>Diagnostic Status</b> <input type="checkbox"/> HIV Infection Suspect acute <input type="checkbox"/> Y HIV infection? <input type="checkbox"/> N <input type="checkbox"/> AIDS	<b>Sex at Birth</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Current Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans to Female <input type="checkbox"/> Trans to Male	<b>Date of Birth</b> ____/____/____ <i>Alias Date of Birth</i> ____/____/____	<b>Country of Birth</b> <input type="checkbox"/> US <input type="checkbox"/> Unk Other (specify): _____	<b>Vital Status</b> <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	<b>Death Date</b> ____/____/____ State/Terr of Death: _____
<b>Marital Status</b> <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> lives w/domestic partner		<b>Ethnicity</b> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Arab <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<b>Race (check all that apply)</b> <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unk		
<b>Residence at Diagnosis</b> <input type="checkbox"/> Same as current Street Address _____ City _____ County _____ State/Country _____ Zip _____						

**VI. FACILITY OF DIAGNOSIS**

Facility Name \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Facility Type:  Private Phys  Hosp Inpt  Hosp Out  Emerg Dept  Other \_\_\_\_\_

**VII. HIV TESTING AND TREATMENT HISTORY**

Date questions answered by patient \_\_\_\_/\_\_\_\_/\_\_\_\_

**First positive HIV test reported by patient:**  
 Date (mo/year) \_\_\_\_/\_\_\_\_  
 Anonymous first positive test? Yes No Unk  
 Specimen type for first positive test: oral blood Unk

**Negative HIV tests reported by patient:**  
 Ever test negative? Yes No Unk  
 Date of most recent negative test (mo/year) \_\_\_\_/\_\_\_\_  
 # of neg tests in 2 yrs before first positive test \_\_\_\_ Unk

**Antiretroviral treatment (ARV) and prophylaxis:**  
 Used ARV to prevent/treat HIV or HepB? Yes No Unk  
 If yes, list medications: \_\_\_\_\_

\_\_\_\_\_  
 Date of first ARV use (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Currently using ARV? Yes No  
 If NO, date of LAST use (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Has patient received PCP prophylaxis? Yes No

**VIII. PATIENT HISTORY - COMPLETE ALL FIELDS**

Before the 1st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
> Sex with male			
> Sex with female			
> Injected non-prescription drugs			
> Received clotting factor for hemophilia/coagulation disorder			
> <b>HETEROsexual relations with any of the following:</b>			
Intravenous/Injection Drug User (IDU)			
Bisexual male (applies to females only)			
Person with hemophilia/coagul disorder w/ documented HIV infection			
Transfusion recipient w/ documented HIV infection			
Transplant recipient w/ documented HIV infection			
Person with AIDS or documented HIV infection, risk not specified			
> Received transfusion (not clot factor) Date 1st: / Date last: /			
> Received transplant of tissue/organs or artificial insemination			
> Worked in healthcare or clinical laboratory <b>OCCUPATION:</b>			
> Perinatally infected			

