

**INSTRUCTIONS FOR COMPLETION OF THE MICHIGAN
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT FORM (ACRF)
DCH FORM #1355
Modified for MDSS Users**

The Michigan Adult HIV/AIDS Confidential Case Report Form (ACRF) DCH Form #1355 is Michigan's version of the Centers for Disease Control (CDC) Adult HIV/AIDS Confidential Form #50.42A. This version now replaces all prior HIV/AIDS case report forms for age 13 and over. A separate form is used for reporting children under age 13 that have been perinatally exposed and/or infected with HIV/AIDS (Pediatric Confidential HIV/AIDS Case Report Form, DCH#1402).

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.

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" or "unknown" to be made.

In addition, sections and fields that are marked "to be completed by MDCH" should be left blank.

Getting Started: To enter a new case of HIV/AIDS in MDSS, select 'New Case' on the left hand side of the screen. For reportable condition, select the 'HIV/AIDS, Adult' case report form. Once selected, activate the pdf to enter information by clicking the "Detail" button (rather than entering information through the HTML form). Once the pdf form is shown, click 'Activate' and data entry may begin.

Date fields: MDSS requires month, day and year in the format mm/dd/yyyy. Therefore, if a date is missing the 'day', enter '1' for the day. If a date is missing the 'month', enter '7' for the month.

For example, for dates without complete date information, only month and year available (i.e., 03/2010), please enter date as 03/01/2010. For dates with only year available (i.e., .././2010), please enter date as 07/01/2010.

Deduplication: Users are asked to merge the patient, however, do not proceed through the case deduplication portion. Simply click 'Place in Queue' and the case will be deduplicated from the queue. This will ensure that case information is not erased by new information.

Contact Information: Please direct all questions for clarification or assistance in completing the adult case report form in MDSS to: Erin Crandell-Alden or Nilsa Mack at 517-335-8165.

Instructions for Completing each Section:

Investigation Information

Please complete to the best of your ability. Patient Status and Case Status are required MDSS variables and must be entered.

SECTION I. Health Department Use Only

Please leave this section blank as it is for state health department use only.

SECTION II. Patient Identifier Information

MDSS Patient ID- Do not enter information here. The ID number is generated by MDSS.

For confidential testers, enter the patient's full name, complete current address, phone number and social security number. It is important to ensure that all data elements for patient address are completed (**MINIMUM:** enter city, county, zip, and state). If available, record maiden names, aliases and/or "Unique Identifier Numbers" (UIN), or City-County Numbers if used.

For anonymous testers, enter 'anonymous' for the patient's first name, and 'anonymous' for the patient's last name.

Parent/Guardian (required if under 18)- Please complete if patient is under 18 as this is an MDSS required variable.

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.

Page 2-----

SECTION IV. Current Provider Information

Please provide the physician, facility, address 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. Use the pulldown menu to select county, which will allow you to select the provider from the list. **IMPORTANT:** Only type in provider information (e.g. last name, first name, address) if you cannot find the provider on the list.

If possible, provide the medical record number used for the patient at this facility.

**SECTION V.
Demographic
Information**

Diagnostic Status

DO NOT SELECT A DIAGNOSTIC STATUS. Unfortunately there is a glitch with this variable and the temporary workaround is to not select any of the options (HIV, AIDs, Unknown).

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

Requires complete date in the format mm/dd/yyyy. See ‘Date Fields’ above for instructions on entering a date with incomplete information.

Country 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

Check correct status

Ethnicity

Ethnicity and race are 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. It is important to ensure that all data elements for residence at diagnosis are completed (MINIMUM: enter city, county, zip, and state).

**SECTION VI.
Facility of
Diagnosis**

First, select the Facility County where the patient was first diagnosed (as HIV positive or as AIDS, accordingly). This will populate the available facilities in the next field. Next, select the facility from the list provided in the ‘Select Facility’ field. If the facility is found, the remaining address information for this field will be complete. If the facility is not found in the list, enter the name of the facility, physician and the address, city, state, zip, country and phone of the facility where the patient was first diagnosed.

Please select the appropriate facility type. If the facility type is not listed, select “Other” and specify, for example, public clinic, counseling and testing site community based organization

Page 3-----

**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 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). Also note if the patient is on PCP prophylaxis.

Note: MDSS dates require month, day and year in the format mm/dd/yyyy. Therefore, if a date is missing the ‘day’, enter ‘1’ for the day. If a date is missing the ‘month’, enter ‘7’ for the month.

**SECTION VIII.
Patient History**

Select Yes/No/Unknown for 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.

Page 4-----

**SECTION IX.
Documented Laboratory Data**

Section 1: HIV Antibody Tests at Diagnosis (First known positive test) Non-type differentiating:

Please document the first HIV Antibody tests at diagnosis (**HIV-1 EIA, HIV 1/ HIV 2 EIA, HIV-1/2 Ag/Ab (4TH generation), HIV-2 EIA, HIV 1 WB, HIV 2 WB, HIV-1 IFA**), recording the **Test Type** (blood or oral fluid), **Rapid Test** (yes or no), **Collection_Date** and **Result** (positive, negative, or indeterminate).

Section 2: HIV Antibody Tests at Diagnosis (First known positive test) Non-type differentiating:

Please document ADDITIONAL HIV Antibody tests at diagnosis (**HIV-1 EIA, HIV 1/ HIV 2 EIA, HIV-1/2 Ag/Ab (4TH generation), HIV-2 EIA, HIV 1 WB, HIV 2 WB, HIV-1 IFA**), recording the **Test Type** (blood or oral fluid), **Rapid Test** (yes or no), **Different manufacturer or methodology from Section 1** (yes or no), **Collection_Date** and **Result** (positive, negative, or indeterminate).

Enter the collection date for the “LAST DOCUMENTED NEGATIVE ANTIBODY TEST”.

Type-Differentiating HIV Antibody Test (HIV-1 vs. HIV-2)

Select the **Test Name, Result** (HIV-1, HIV-2, Both (undifferentiated), **Neither** (negative)), and **Collection_Date**.

Positive HIV detection tests:

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

Viral load tests (earliest and most recent):

Please record both the **earliest and most recent viral load tests**.

IMPORTANT: Please select a Result_ Interpretation (=, <, >) for each viral load test.

Immunologic lab tests:

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**.

Enter only numeric values for both CD4 counts and percents, e.g. do not type in <, >, or commas. If the value of a CD4 count or percent is less than (<) something, enter only the numeric value. For example, if it is <5 cells/ul, enter 5 under CD4 Count. CD4 count and percent values between 0 and 1 should be entered as 0. For example, if it is 0.7%, enter 0 under “cells/ul(%)”.

Only enter one CD4 per section. For example, for “At or closest to current diagnostic status” section” only enter one CD4- **do not use the second line of this section**. The same for “First <200 or <14% of total lymphocytes” section-only enter one CD4-**do not use the second line of this section**.

Physician diagnosis:

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.

Genotype testing:

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

Page 5-----

**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.

Lab Results- Please leave blank.

Blank Page

Other Information- Please leave blank.

Comments or Additional Information- Please add any additional laboratory, clinical, partner services or other relevant information here.