STICKY #:26-

Michigan Adult HIV Confidential Case Report Form

(Patients ≥ 13 years of age)

DCH FORM #1355 Modified September 2019

eHARS Entry Date:

PSWeb Entry Date:

I. SURVEILLANCE USE ONLY

Document ID	Soundex Code	Date Received at Surveillance	PSWeb Person ID#	State Number
MI00-		_____/_____/_____		

Document Source	Report Status	Report Medium	Surveillance Method
	New Update		A F P R

II. PATIENT IDENTIFIER INFORMATION

Patient Legal Name Last:_____ First:_____ Middle:_____

☐ Alias ☐ Maiden Last:_____ First:_____ Middle:_____

Address Type: ☐ Residential ☐ Correctional ☐ P.O. ☐ Temporary ☐ Homeless ☐ Shelter ☐ Foster Home

Current Address:_____ City:_____ County:_____

State:_____ Zip:_____ Phone:_____ Mobile:_____ SS#:_____

Residence at Diagnosis (check all that apply): ☐ Residence at HIV diagnosis ☐ Residence at Stage 3 (AIDS) diagnosis

☐ Same as Current Address Address:_____

City:_____ County:_____ State/Country:_____ Zip:_____

III. FACILITY OF DIAGNOSIS

☐ **Site of 1st Positive test for HIV Diagnosis** ☐ **Site of Stage 3 (AIDS) Diagnosis**

Facility Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Provider Name Last:_____ First:_____ Provider Specialty:_____

Facility Type: ☐ Private Provider ☐ Hosp Inpt ☐ Hosp Out ☐ ED ☐ ID Clinic ☐ LHD ☐ CBO ☐ CTR ☐ Other

VI. CURRENT PROVIDER OF HIV CARE (☐ Same as Facility of Diagnosis)

Provider Name Last:_____ First:_____ Facility:_____

City:_____ State:_____ Zip:_____ Phone:_____ Med Rec No:_____

V. FACILITY PROVIDING INFORMATION (☐ Same as Facility of Diagnosis) (☐ Same as Current Provider of Care)

Date Form Completed:_____/_____/_____ Person Completing Form:_____

Facility Completing Form:_____ Phone:_____

VI. DEMOGRAPHIC INFORMATION – COMPLETE ALL FIELDS

Case Status: ☐ HIV Infection ☐ Stage 3 (AIDS) Do you suspect this is an acute (recent) infection? ☐ Y ☐ N

Sex at Birth	Gender Identity	Date of Birth	Country of Birth	Vital Status	Death Date	Marital Status
☐ Male ☐ Female	☐ Male ☐ Female ☐ Trans to Female ☐ Trans to Male	___/___/____ Alias DOB ___/___/____	☐ US ☐ Unk Other (specify): _____	☐ Alive ☐ Dead ☐ Unk	____/____/____ State/Terr of Death:_____	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Lives w/ Ptnr

Race: ☐ Black (African American) ☐ White ☐ Asian ☐ American Indian/Alaskan ☐ Native Hawaiian/PI

Ethnicity: Arab ☐ Y ☐ N ☐ Unk Latino/Hispanic ☐ Y ☐ N ☐ Unk

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before HIV Diagnosis, patient had:	Y	N	Unk	Before HIV Diagnosis, patient had:	Y	N	Unk
Sex with a male				*HETEROSEXUAL SEX WITH:*			
Sex with a female				- *An injection drug user (IDU)*			
Injected non-prescription drugs				- *A bisexual male (females only)*			
Transplant/transfusion/clotting disorder*				- *Person known to have HIV/AIDS*			
High risk sex (detail in comment section)				Was patient perinatally infected?			

**and is claiming this as their source of HIV infection*

VIII. TREATMENT/SERVICES REFERRALS (MI law requires providers to notify known partners or request help from LHD)

Patient Informed of HIV infection? ☐ Y ☐ N ☐ Unk

Patient's partners will be notified of exposure and counseled by: ☐ Local Health Department ☐ Clinical Care Provider

IX. WOMEN ONLY

Patient currently pregnant? ☐ Y ☐ N ☐ Unk IF YES, referred to OB? ☐ Y ☐ N ☐ Unk EDC (Due Date):____/____/____

Patient delivered live infants? ☐ Y ☐ N ☐ Unk IF YES, Most Recent Delivery Date:_____/_____/_____

Delivery Hospital:_____ City:_____ State:____ Child Name:_____

X. DOCUMENTED LAB DATA **PATIENT NAME:**_____

Questions concerning lab results? CALL US at 313 456-1571 or 517 335-8165

****You may add copies of lab results to this form and may fax form to 313 456-1580 (SE MI) or 517 335-8121****

HIV DIAGNOSTIC TESTS – please report all positive and subsequent negative tests

Type of Test ******At least 2 Antibody Tests must be indicated for an HIV diagnosis***** ***IA = ImmunoAssay***	**Collection Date**	Rapid Test	Positive or Reactive	Reactive for Ag	Reactive for Ab	HIV1 Ab Positive	HIV 2 Ab Positive	Indeterminate	Undifferentiated	Negative or NonReactive	Manufacturer
HIV-1/2 Ag/Ab **Lab** IA (*Discriminating & Differentiating Screen*)		N									BioPlex Screen
HIV-1/2 Ag/Ab **Rapid** IA (4th Gen *Discriminating Screen*)		Y									Determine rapid
HIV-1/2 Ag/Ab **Lab** IA (4th Gen Screen)		N									
HIV-1/2 Ab IA (2nd or 3rd Gen Screen)		Y N									
HIV1/HIV 2 Type Differentiating IA (Supplemental Test)		Y									Geenius Ab confirm
HIV-1 Western Blot (Supplemental Test)		N									
HIV-1 RNA/DNA Qualitative NAAT		N									
OTHER:_____											
Last Negative Test (prior to HIV diagnosis)		Y N									

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider? ☐ Yes ☐ No ☐ Unk

IF YES, please provide date of documentation by care provider:_____/_____/_____

HIV CARE TESTS

HIV-1 RNA Assay Quantitative Viral Load

☐ Detectable ☐ Undetectable Copies/mL _____ Collection Date_____/_____/_____

☐ Detectable ☐ Undetectable Copies/mL _____ Collection Date_____/_____/_____

CD4 Count at or closest to current diagnostic status

CD4 Count_____cells/ul CD4 Percentage_____% Collection Date_____/_____/_____

First CD4 Count <200 total lymphocytes

CD4 Count_____cells/ul CD4 Percentage_____% Collection Date_____/_____/_____

HIV Genotype

☐ Sanger Sequence ☐ Deep or NextGen Sequence Collection Date_____/_____/_____

XI. STAGE 3 (AIDS) OPPORTUNISTIC ILLNESSES (See Instructions for a list of opportunisitic illnesses)

Name of Opportunistic Illness:_____ Illness Diagnosis Date_____/_____/_____

XII. HIV TESTING AND TREATMENT HISTORY (TTH)

Date questions answered by patient: _____/_____/_____

Main Source of TTH Info: ☐ Medical Record Review ☐ Patient Interview ☐ Provider Report ☐ Other

First Positive Test Reported by Patient:

Ever have previous positive HIV test? ☐ Y ☐ N ☐ Unk

Date of 1st positive HIV test:_____/_____/_____

Anonymous 1st positive test? ☐ Y ☐ N ☐ Unk

Negative Tests Reported by Patient:

Ever test negative? ☐ Y ☐ N ☐ Unk

Date of most recent negative test: _____/_____/_____

# of negative tests in 24 mo. before 1st positive test:_____ ☐ Unk

History of ANY Antiretroviral Treatment (ARV) Use: CHECK HERE IF NO ARV USE EVER: ☐

For HIV Tx? ☐ ARV used:_____Date began: _____/_____/_____ Date of last use: _____/_____/_____

For PrEP? ☐ ARV used:_____Date began: _____/_____/_____ Date of last use: _____/_____/_____

For PEP? ☐ ARV used:_____Date began: _____/_____/_____ Date of last use: _____/_____/_____

For Preg mom? ☐ ARV used:_____Date began: _____/_____/_____ Date of last use: _____/_____/_____

For Hep B Tx? ☐ ARV used:_____Date began: _____/_____/_____ Date of last use: _____/_____/_____

Currently using ARV? ☐ Yes, Date of most recent use: _____/_____/_____ ☐ No, Date of last use: _____/_____/_____

XIII. COMMENTS_____

_____