

**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT**

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

I. HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED

Month Day Year

Report Source

Second level Source

Soundex <input type="text"/>	Date Received Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	Laboratory Tracking # <input type="text"/>	Report Status: <input type="checkbox"/> New Report <input type="checkbox"/> Update	State No. <input type="text"/>
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II. PATIENT INFORMATION FOR HIV AND AIDS - MUST BE COMPLETED

- Patient Identifier Information is not transmitted to CDC -

Patient's Name _____ Phone No. () _____ Social Security No. _____
(Last, First, M.I) Other names (AKA, Maiden Name, etc.) _____

Address _____ City _____ Ward _____ State _____ Zip Code _____ Country _____

DIAGNOSTIC STATUS AT REPORT (check one): <input type="checkbox"/> 1 HIV Infection (not AIDS) <input type="checkbox"/> 2 AIDS	AGE AT DIAGNOSIS: <input type="text"/> <input type="text"/> Years <input type="text"/> <input type="text"/> Years	DATE OF BIRTH: Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	CURRENT STATUS: Alive <input type="checkbox"/> 1 Dead <input type="checkbox"/> 2 Unk. <input type="checkbox"/> 3	DATE OF DEATH: Month <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	STATE/TERRITORY OR COUNTRY OF DEATH:
ETHNICITY: (select one) <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 3 Unknown <input type="checkbox"/> 2 Not Hispanic or Latino <i>If Hispanic, please check one</i> <input type="checkbox"/> 3A Mexican <input type="checkbox"/> 3B Puerto Rican <input type="checkbox"/> 3C Cuban <input type="checkbox"/> 3D Central American <input type="checkbox"/> 3E South American <input type="checkbox"/> 3F Other		RACE: (select one or more) <input type="checkbox"/> 1 American Indian/Alaska Native <input type="checkbox"/> 2 Asian <input type="checkbox"/> 3 Black or African American <input type="checkbox"/> 4 Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 5 White <input type="checkbox"/> 9 Unknown		TRANSGENDER: Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/>	
RESIDENCE AT DIAGNOSIS: City _____ County _____ State/Country _____ ZIP Code _____		Incarcerated in DC..... <input type="checkbox"/> Incarcerated outside of DC <input type="checkbox"/> Homeless <input type="checkbox"/> Detox <input type="checkbox"/> Check if at time of diagnosis			

III. REPORTING INFORMATION

IV. PATIENT HISTORY (Respond to ALL Categories)

Reporting Facility Name _____

City _____

State/Country _____

FACILITY SETTING (check one)
 1 Public 3 Federal
 2 Private 9 Unknown

FACILITY TYPE (check one)
 01 Physician, HMO 29 Community Health Center
 30 Correctional Facility 32 Hospital, Outpatient
 31 Hospital, Inpatient 99 Unknown
 88 Other (specify) _____

PRIOR TO THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD ANY OF THE FOLLOWING RISK FACTORS

	Yes	No	Unk.
• Sex with male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sex with female	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Injected nonprescription drugs.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Specify <input type="checkbox"/> 1 Factor VIII <input type="checkbox"/> 2 Factor IX <input type="checkbox"/> 8 Other			
disorder: (Hemophilia A) (Hemophilia B) (specify) _____			
• HETEROSEXUAL relations with any of the following			
• Intravenous/injection drug user	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Bisexual male (female only)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transfusion recipient with documented HIV infection.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transplant recipient with documented HIV Infection.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with AIDS or documented HIV infection, risk not specified.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Month <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/> Hospital _____			
• Received transplant or tissue/organs or artificial insemination	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Occupational exposure (Specify occupation) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Perinatal Infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

V. LABORATORY DATA

<p>1. HIV ANTIBODY TEST AT DIAGNOSIS: Pos Neg Ind Done</p> <p>(Indicate first test)</p> <p>• HIV-1 EIA <input type="checkbox"/>1 <input type="checkbox"/>0 - <input type="checkbox"/>9</p> <p>• HIV-1/2 combination EIA..... <input type="checkbox"/>1 <input type="checkbox"/>0 - <input type="checkbox"/>9</p> <p>• HIV-1/2 Western blot/IFA <input type="checkbox"/>1 <input type="checkbox"/>0 <input type="checkbox"/>8 <input type="checkbox"/>9</p> <p>• Other HIV antibody test <input type="checkbox"/>1 <input type="checkbox"/>0 <input type="checkbox"/>8 <input type="checkbox"/>9</p> <p>(specify): _____</p> <p>2. POSITIVE HIV DETECTION TEST: (Record <u>earliest</u> test)</p> <p><input type="checkbox"/> culture <input type="checkbox"/> antigen</p> <p>• HIV PCR, DNA or RNA probe.....</p> <p>• NAT (Nucleic Acid Test).....</p> <p>• Other HIV-1AB <input type="checkbox"/>1 <input type="checkbox"/>0 - <input type="checkbox"/></p> <p>(specify): _____</p> <p>3. VIRAL LOAD TEST: (Record most recent test)</p> <p>Test type* COPIES/ML</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>TEST DATE</p> <p>Mo. Day Yr.</p> <p>• Date of last documented <u>negative</u> HIV test (specify type): _____</p> <p>Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?</p> <p>Yes No Unk. <input type="checkbox"/>1 <input type="checkbox"/>0 <input type="checkbox"/>9</p> <p>Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, provide date of documentation by a physician</p> <p>4. IMMUNOLOGIC LAB TESTS:</p> <p>AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS</p> <p>• CD4 Count <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• CD4 Percent <input type="checkbox"/> <input type="checkbox"/> % Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>First <200 ul or <14%</p> <p>• CD4 Count <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• CD4 Percent <input type="checkbox"/> <input type="checkbox"/> % Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Resistance Tests:</p> <p>• Genotyping (send copy) Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• Phenotyping (send copy) Mo. Yr. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. other

- Provider Identifier information is not transmitted to CDC -

Provider's Name _____ Phone No. () _____ Patient Medical Record No. _____
 (Last, First, M.I.)

Hospital/Facility _____ Person Completing Form _____

Facility Address _____ Phone No. () _____

Email _____ Fax () _____

VI. REASON FOR VISIT: (mark all that apply)

- | | |
|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> 1 SYMPTOMATIC FOR HIV/AIDS | <input type="checkbox"/> 7 PRENATAL/OB RELATED |
| <input type="checkbox"/> 2 CLIENT REFERRAL | <input type="checkbox"/> 8 COURT ORDERED |
| <input type="checkbox"/> 3 PROVIDER REFERRAL | <input type="checkbox"/> 9 TB RELATED |
| <input type="checkbox"/> 4 STD RELATED | <input type="checkbox"/> 10 OCCUPATIONAL EXPOSURE |
| <input type="checkbox"/> 5 DRUG TRMT RELATED | <input type="checkbox"/> 11 SEXUAL ASSAULT VICTIM |
| <input type="checkbox"/> 6 FAMILY RELATED | <input type="checkbox"/> 12 MENTAL HEALTH PATIENT |
| | <input type="checkbox"/> 99 UNKNOWN |

ADDITIONAL RISK INFORMATION (mark all that apply)

- | | |
|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> 1 SEX WHILE USING NON-INJ DRUGS | <input type="checkbox"/> 3 STD DIAGNOSIS |
| <input type="checkbox"/> 2 SEX FOR DRUGS/MONEY/SHELTER | <input type="checkbox"/> 4 SEX WHILE USING ALCOHOL |

CO-INFECTIONS

	Yes	No	Unk.	Diagnosis Date	Acute	Chronic
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	
Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	
Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	

VII. CLINICAL STATUS

CLINICAL RECORD REVIEWED:	Yes No <input type="checkbox"/> <input type="checkbox"/>	ENTER DATE PATIENT WAS DIAGNOSED AS:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Mo. Yr. <input type="text"/> <input type="text"/>	Symptomatic (not AIDS):	Mo. Yr. <input type="text"/> <input type="text"/>
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AIDS INDICATOR DISEASE	Initial Def.	Diagnosis Pres.	Initial Date		AIDS INDICATOR DISEASE	Initial Def.	Diagnosis Pres.	Initial Date	
			Mo.	Yr.				Mo.	Yr.
Candidiasis, bronchi, trachea or lungs	1	NA	<input type="text"/>	<input type="text"/>	Lymphoma, Burkitt's (or equivalent term)	1	NA	<input type="text"/>	<input type="text"/>
Candidiasis, esophageal	1	2	<input type="text"/>	<input type="text"/>	Lymphoma, immunoblastic (or equivalent term)	1	2	<input type="text"/>	<input type="text"/>
Carcinoma, invasive cervical	1	NA	<input type="text"/>	<input type="text"/>	Lymphoma, primary in brain	1	NA	<input type="text"/>	<input type="text"/>
Coccidioidomycosis, disseminated or extrapulmonary	1	NA	<input type="text"/>	<input type="text"/>	Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary*	1	NA	<input type="text"/>	<input type="text"/>
Cryptococcosis, extrapulmonary	1	NA	<input type="text"/>	<input type="text"/>	M. tuberculosis, pulmonary*	1	NA	<input type="text"/>	<input type="text"/>
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA	<input type="text"/>	<input type="text"/>	M. tuberculosis, disseminated or extrapulmonary*	1	NA	<input type="text"/>	<input type="text"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	2	<input type="text"/>	<input type="text"/>	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2	<input type="text"/>	<input type="text"/>
Cytomegalovirus retinitis (with loss of vision)	1	NA	<input type="text"/>	<input type="text"/>	Pneumocystis carinii pneumonia	1	NA	<input type="text"/>	<input type="text"/>
HIV encephalopathy	1	NA	<input type="text"/>	<input type="text"/>	Pneumonia, recurrent, in 12 mo. period	1	NA	<input type="text"/>	<input type="text"/>
Herpes simplex: chronic ulcer(s) (>1mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA	<input type="text"/>	<input type="text"/>	Progressive multifocal leukoencephalopathy	1	NA	<input type="text"/>	<input type="text"/>
Histoplasmosis, disseminated or extrapulmonary	1	NA	<input type="text"/>	<input type="text"/>	Salmonella septicemia, recurrent	1	NA	<input type="text"/>	<input type="text"/>
Isosporiasis, chronic intestinal (>1mo. duration)	1	NA	<input type="text"/>	<input type="text"/>	Toxoplasmosis of brain	1	NA	<input type="text"/>	<input type="text"/>
Kaposi's sarcoma	1	2	<input type="text"/>	<input type="text"/>	Wasting syndrome due to HIV	1	2	<input type="text"/>	<input type="text"/>

Def. = definitive diagnosis Pres. = presumptive diagnosis

*RVCT CASE NO.:

• If HIV tests were not positive or were not done, does this patient have any immunodeficiency that would disqualify him/her from the AIDS case definition? Yes No Unknown

VIII. TREATMENT/SERVICES REFERRALS

<p>Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>This patient's partners will be notified about their HIV exposure and counseled by : <input type="checkbox"/> Health department <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown</p> <p>Physicians/Providers: YOU MAY CONTACT DOH HIV/AIDS ADMINISTRATION FOR PARTNER COUNSELING AND NOTIFICATION SERVICES</p>	<p>This patient is receiving or has been referred for:</p> <p>• HIV related medical services..... Yes <input type="checkbox"/> No <input type="checkbox"/> NA - Unk. <input type="checkbox"/></p> <p>• Substance abuse treatment services Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unk. <input type="checkbox"/></p>										
<p>This patient received or is receiving:</p> <p>• Anti-retroviral therapy Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/></p> <p>• PCP prophylaxis Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/></p>	<p>This patient has been enrolled at:</p> <table style="width: 100%;"> <tr> <td>Clinical Trial</td> <td>Clinic</td> </tr> <tr> <td><input type="checkbox"/> NIH-sponsored</td> <td><input type="checkbox"/> HRSA-sponsored</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Unknown</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>	Clinical Trial	Clinic	<input type="checkbox"/> NIH-sponsored	<input type="checkbox"/> HRSA-sponsored	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
Clinical Trial	Clinic										
<input type="checkbox"/> NIH-sponsored	<input type="checkbox"/> HRSA-sponsored										
<input type="checkbox"/> Other	<input type="checkbox"/> Other										
<input type="checkbox"/> None	<input type="checkbox"/> None										
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown										
<p>This patient's medical treatment is primarily reimbursed by:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Medicaid</td> <td><input type="checkbox"/> Private insurance/HMO</td> </tr> <tr> <td><input type="checkbox"/> No coverage</td> <td><input type="checkbox"/> Other Public Funding</td> </tr> <tr> <td><input type="checkbox"/> Clinical trial/ government program</td> <td><input type="checkbox"/> Unknown <input type="checkbox"/> Medicare</td> </tr> <tr> <td></td> <td><input type="checkbox"/> ADAP</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Alliance/Chartered Health</td> </tr> </table>		<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private insurance/HMO	<input type="checkbox"/> No coverage	<input type="checkbox"/> Other Public Funding	<input type="checkbox"/> Clinical trial/ government program	<input type="checkbox"/> Unknown <input type="checkbox"/> Medicare		<input type="checkbox"/> ADAP		<input type="checkbox"/> Alliance/Chartered Health
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private insurance/HMO										
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<input type="checkbox"/> Clinical trial/ government program	<input type="checkbox"/> Unknown <input type="checkbox"/> Medicare										
	<input type="checkbox"/> ADAP										
	<input type="checkbox"/> Alliance/Chartered Health										
<p>FOR WOMEN:</p> <p>• This patient is receiving or has been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>• Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>• Anticipated Due Date <input type="text"/> Mo. <input type="text"/> Yr. <input type="checkbox"/> Unknown</p> <p>• Has this patient delivered live-born infants since being diagnosed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p style="margin-top: 5px;">If yes, provide birth information for the most recent birth below. Provide the number of children delivered since diagnosis <input style="width: 30px;" type="text"/></p>											
<p>Child's Birth Date:</p> <table style="width: 100%; text-align: center;"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> </table> <p>(Most Recent Birth)</p>	Month	Day	Year	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<p>Hospital of Birth: _____ <small>*Required Field</small></p> <p>City _____ State: _____</p>				
Month	Day	Year									
<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>									
<p>Child's Soundex:</p> <p><input style="width: 40px;" type="text"/> State No. _____</p>											

IX. HIV TESTING HISTORY

<p>HAS THE PATIENT EVER HAD A RAPID HIV SCREENING TEST?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p> <p>If Yes <input type="checkbox"/> Oral <input type="checkbox"/> Blood <input type="checkbox"/></p>	<p align="center">FIRST POSITIVE HIV TEST</p> <p align="center">DATE:</p> <p align="center">Month Day Year</p> <p align="center"> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> </p>	<p align="center">EVER HAVE NEGATIVE HIV TEST?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/></p> <p align="center">Name of facility where tested _____ State Tested <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p align="center">PATIENT SELF-REPORTED</p> <p align="center">DATE OF LAST negative HIV Test</p> <p align="center">Month Day Year</p> <p align="center"> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> (specify type) _____ </p>
<p>NUMBER OF TIMES TESTED: for HIV in past 2 years or in the 2 years before first positive test (include current or first positive test)</p> <p align="center"> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> </p>		<p align="center">EVER TAKEN ANY ARV OR HIV MEDICINES?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/></p>
<p>TYPES OF ARV MEDICATION</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>SPECIFY OTHER MEDICATIONS</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>FIRST DAY OF ARV OR HIV MEDICATION</p> <p align="center">Month Day Year</p> <p align="center"> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> </p> <p>LAST DAY OF ARV OR HIV MEDICATION</p> <p align="center">Month Day Year</p> <p align="center"> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> </p>

X. HEALTH DEPARTMENT USE ONLY

<p>Casework needed to complete report:</p> <p>00 = arrived complete 01 = demographic data 02 = residence at diagnosis 03 = hospital/facility 04 = risk factor 05 = date of first dx 06 = laboratory data 07 = physician info 08 = patient identifier 11 = clinical status/AIDS or OIs 12 = treatment/services referral 13 = HIV testing hx</p> <hr/> <p>NIR Status: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.</p> <p>NIR <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Physician notified by telephone <input type="checkbox"/> Physician notified by letter <input type="checkbox"/> Returned for additional investigation <input type="checkbox"/> Date _____</p>	<p>Current Status: date / / _____</p> <p>1 = open (still being investigated) 2 = closed-dead 3 = closed-refused 4 = closed-lost to follow-up 5 = investigated (risk still unknown) 6 = reclassified (risk has been found) Enter month/year resolved _____</p> <p>Current Status: date / / _____</p> <p>1 = open (still being investigated) 2 = closed-dead 3 = closed-refused 4 = closed-lost to follow-up 5 = investigated (risk still unknown) 6 = reclassified (risk has been found) Enter month/year resolved _____</p> <p>Field Supervisor _____ Date reviewed / / _____ Follow-up date / / _____ Follow up plan _____ _____ _____ _____</p>
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COMPONENTS OF UNIQUE IDENTIFIER

First two letters of last name	Number of letters in last name	SEX	DATE OF BIRTH	Last four digits of Social Security Number						
		<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">MM</td> <td style="width:33%;">DD</td> <td style="width:33%;">YY</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	MM	DD	YY				
MM	DD	YY								

