Rev. 05/04/2017

HAHSTA

(HIV/AIDS, Hepatitis, STD, and TB Administration)

Notifiable Disease Report Form Technical Guidance

for HIV/AIDS, Viral Hepatitis, and Sexually Transmitted Infections

Contents

Reporting Regulations

The DC Municipal Regulations (DCMR) requires providers or person's in charge of a reportable disease/condition to notify the health department of a disease. Chapter 22, B201 of the DCMR contains the regulations for communicable and reportable diseases. HIV/AIDS, viral hepatitis, and sexually transmitted infections (syphilis, gonorrhea, and chlamydia) are required to be reported within 48 hours of diagnosis. Upon receiving notification of an infection, the health department shall make any investigation that is deemed necessary for the purposes of determining the source of infection and the nature of treatment. To facilitate, the investigation, any entity providing health or medical services shall make medical records and histories available for review. Information collected is used for statistical, public health, epidemiological, and surveillance purposes. The health department's collection of personal identifying and private health information is solely for public health purposes and will not be disclosed for other purposes without the individual's written consent or a court order.

The Notifiable Disease Report Form

The HAHSTA Notifiable Disease Report Form should be completed in its entirety to report all new cases of HIV/AIDS, Hepatitis and Sexually Transmitted Infections within the District of Columbia. The one page form is divided into five major sections with each section including information required to be reported to the Center for Disease Control and Prevention. All new diagnoses are required to be reported within 48 hours of confirmation. This form is available as a fillable PDF document or standard PDF file. The fillable PDF can be pre-populated with the Health Provider Information and saved on a computer. You can hover the mouse/cursor over a field to see a hint on what information is expected. The Standard PDF forms should be completed in blue or black ink only. Print neatly and use capital letters if possible. Do not use cursive. To be determined at a future date, an Internet-based form that complies with HIPAA will be made available and allow direct submission to the health department.

Form Handling

The HAHSTA Notifiable Disease Report Form should be sent to the District of Columbia Department of Health within 48 hours of diagnosis or suspicion of infection. Forms can be delivered in three ways:

1) Facsimile transmission -to secured line ONLY at 202-727-4934. Sending forms to any other number is NOT ACCEPTABLE.

2) Mail -Forms may be sent U.S. Postal Service in sealed doubled envelopes marked CONFIDENTIAL to the following address (do not indicate any specific diseases on the outside of the envelope):

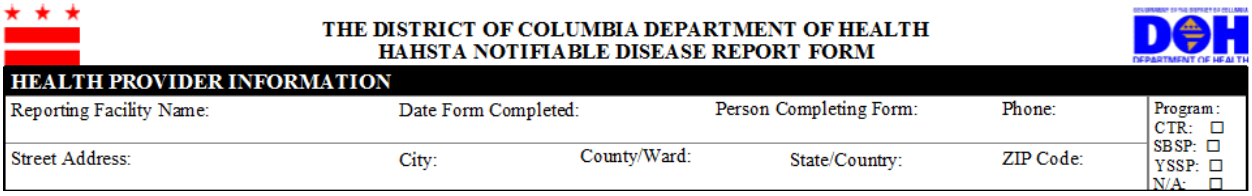
The Government of the District of Columbia
Department of Health
Strategic Information Division
899 North Capitol Street NE, 4th Floor
Washington, DC 20002

3) Hand Delivered- Forms can be hand delivered to the above address during regular business hours (8:15AM to 4:45PM).

It is not acceptable to e-mail private health information.

Completing the Form

Section 1: Health Provider Information



THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HAHSTA NOTIFIABLE DISEASE REPORT FORM

HEALTH PROVIDER INFORMATION					
Reporting Facility Name:	Date Form Completed:		Person Completing Form:	Phone:	Program: CTR: ☐ SBSP: ☐ YSSP: ☐ N/A: ☐
Street Address:	City:	County/Ward:	State/Country:	ZIP Code:	

This section reports the health provider entity information.

1) Reporting Facility Name
   - Enter the name of the facility, practice, or organization reporting the case to the health department.
   - If facility has more than one location or separate department for testing and reporting be sure to specify.

2) Date Form Completed:
   - Date in which the form is completed
   - May differ from the date the information was collected.

3) Person Completing Form:
   - First and last name of the person who completed the form
   - This should be the designated person responsible for the information provided and may differ from the person who collected the information

4) Phone:
   - Record the telephone number of the person completing the form.

5) Program:
   - Select the program under which the diagnosis occurred
     - CTR- Counseling, Testing, and Referral Program (HIV Prevention)
     - SBSP- School Based Screening Program (STD Control)
     - YSSP- Youth STI Screening Program (STD Control)
     - N/A- Check this box if the diagnoses did not occur as a part of any of the aforementioned programs.

6) Street Address, City, County/Ward, State/County and Zip Code of the facility completing the form.

Section 2: Patient Demographics

PATIENT IDENTIFIERS AND DEMOGRAPHICS				
Last Name:	First Name:	Date of Birth:	Social Security Number:	Medical Record Number:
Address Type (select one): ☐Residential ☐Correctional Facility ☐Foster Home ☐Homeless ☐Postal ☐Shelter ☐Temporary ☐Bad/Invalid Address				
Current Street Address:			Apt #:	Phone:
City:	County/Ward:		State/Country:	ZIP Code:

Sex assigned at birth:	**Gender identity**:	**Ethnicity**:	**Race** (select all that apply):	Was the patient notified that they may be contacted by DOH Disease Intervention Specialists (DIS)?
☐Male ☐Female If female, **pregnant**? ☐Yes ☐No If yes, weeks: _____	☐Male ☐Female ☐Transgender Female ☐Transgender Male ☐Other: _____	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown	☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Unknown	☐Yes ☐No

Patient Demographics are recorded in this section of the form.

1) Last Name:
   - Enter the last name of the patient

2) First Name:
   - Enter the first name of the patient

3) Date of Birth:
   - Enter the date of birth of the patient

4) Social Security Number
   - Enter the 9-digit social security number for the patient
     - If all nine digits are not known, enter the last four digits in the last space
     - If the patient does not have a social security number, please leave the field blank.

5) Medical record number:
   - Enter the medical record number used to identify the patient at the reporting facility
     - If the patient does not have a medical record number, please leave the field blank

6) Address type:
   - Patient's current residential address.
     - Residential- patient is currently residing at the address listed.
     - Correctional Facility- patient is currently residing within a correctional facility.
     - Foster Home- patient is residing in a foster home.
     - Homeless- patient does not have a physical address in which they reside but you have an address that most accurately describes where they stay.
     - Postal- postal box address.
     - Shelter- patient is currently residing in a shelter home.
     - Temporary- the address given is not a permanent address. (Ex. patient living with friend, away at college or with a family member)

- Bad/Invalid Address- the address provided by the patient does not exist. If you are able to, the DC Master Address Repository can be searched for valid District of Columbia addresses here: http://dcatlas.dcgis.dc.gov/mar/.

7) Current Street Address:
    - Enter the patient's current street number and name.

8) Apartment number:
    - If apartment number is not applicable, please leave it blank.

9) Phone:
    - Enter the patient's current phone number.
        - If phone number is unknown, please leave it blank.

10) City:
    - Enter the city of the patient's current residential address.

11) County/Ward:
    - Enter the county or ward of the patient's current residential address
        - If the patient's residence is in the District of Columbia, please enter the ward
        - If the patient's residence is outside of the District of Columbia, please enter the county
        - Both county and ward should not be entered

12) State/Country:
    - Enter patient's current state and country of residence.

13) ZIP Code:
    - Enter the patient's ZIP code.

14) Sex at Birth:
    - Enter the sex assigned at birth for the patient
        - This may differ from the gender identity of the patient.

15) If the patient is a female:
    - indicate whether the patient is currently pregnant by checking yes or no
        - If the patient is pregnant, please enter the number of weeks she has been pregnant.

16) Gender Identity:
    - Enter the gender identified by the patient

17) Ethnicity:
    - Enter the applicable response

- If no ethnicity information is available, select Unknown. This generally is related to whether or not the patient's lineage includes a Spanish speaking country.

18) Race:
    - Enter all applicable selections (persons may identify with multiple races)
        - This question should be answered even if information was entered for ethnicity
        - If no race information is available, select Unknown

19) DOH Disease Intervention Specialists (DIS):
    - Select Yes if the patient was notified that they may be contacted by a Disease Intervention Specialist from the DC DOH.
    - Otherwise select No

Section 3: Patient History

PATIENT HISTORY		
Date of Exam: / / Reason for Exam (chief complaint or type of visit):		
Gender of patient's sex partner(s): ☐Male ☐Female ☐Both	Injection Drug Use: ☐Yes ☐No ☐Unk	Is/was the patient on PrEP: ☐Yes ☐No

1) Date of Exam:
    - Enter the date the exam (visit) leading to the diagnosis was conducted

2) Reason for Exam:
    - Enter the patient's chief complaint or reason for the exam.
        - Example: annual sexual transmitted disease testing, fatigue, sore throat, fever etc.
3) Gender of patient's sex partner(s)
    - If you have talked to your patient about his/her sex partner(s), please indicate if the partner was either male, female, or both.
4) Injection Drug Use (IDU)
    - If you know whether or not the patient is actively doing injection drugs, please check the corresponding response of Yes or No. If you did not ask about the patient's activity with IDU, please select Unk.
5) PrEP
    - Enter Yes if the patient is currently taking antiretroviral medication (i.e., Truvada) as Pre-exposure prophylaxis (PrEP).
    - Enter No if the patient is NOT currently taking antiretroviral medication as PrEP.
    - If the patient's current PrEP use is unknown, please leave it blank.

Section 4: Diagnosis and Treatment

DIAGNOSIS AND TREATMENT (Include lab results when sending case report forms)

CHLAMYDIA

Positive specimen site (select all that apply):
☐Genital ☐Urine ☐Rectum
☐Pharynx ☐Other: _____

Date treated: / /
Treatment: ☐Azithromycin 1g ☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days
☐Other: _____

Was the patient offered Chlamydia-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____

GONORRHEA

Positive specimen site (select all that apply):
☐Genital ☐Urine ☐Rectum
☐Pharynx ☐Other: _____

Date treated: / /
Treatment: ☐Ceftriaxone 250mg IM ☐Azithromycin 1g ☐Cefixime 400mg PO
☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days ☐Gentamicin 240mg IM
☐Gemifloxacin 320mg PO ☐Other: _____

Was the patient offered Gonorrhea-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____

HEPATITIS B (select all that were positive/reactive)

☐HBsAg ☐HBsAb
☐HBcAb, Total ☐HBcAb, IgM

Date Diagnosed: / / **Diagnosis type**: ☐Past ☐Current **Vaccinated?** ☐
Describe **symptoms**, if any: _____

HEPATITIS C

(select all that were positive/reactive)
☐HCV Ab ☐HCV RNA

Date Diagnosed: / / **Diagnosis type**: ☐Past ☐Current **Treated?** ☐
Describe **symptoms**, if any: _____

HIV (check all that were positive/reactive)

☐HIV Rapid Test ☐HIV-1/2 Ag/Ab
☐HIV-1/2 type differentiating
☐HIV-1 WB ☐HIV RNA or NAT
Diagnosis documented by a physician?
☐Yes ☐No

Date Diagnosed: / /
Was client informed of HIV status? ☐Yes ☐No ☐Unknown
Was client linked to HIV medical care? ☐Yes ☐No ☐Unknown
If Yes, where linked? _____ ☐Check if SAME as Reporting Facility
Did you verify client attended appointment for HIV care? ☐Yes ☐No ☐Unknown

SYPHILIS

☐Primary (chancre)
☐Secondary (rash, etc.)
☐Early Latent (<1 yr.)
☐Late Latent (>1 yr.)
☐Unknown duration
☐Congenital

With manifestation of:
☐Neurologic
☐Ocular
☐Otic

Date of last RPR: / / **Result**: ☐Pos ☐Neg ☐Unk **Quant. RPR**: 1: ____
Date treated:
Treatment: ☐Bicillin 2.4mu IM x1 ☐Bicillin 2.4mu IM x3 wks ☐Other: _____
☐Doxycycline 100mg po bid x14 days ☐Doxycycline 100mg po bid x28 days
Describe any **symptoms**: _____
If neurosyphilis, **CSF-VDRL Date**: **CSF-VDRL Titer Results**:

OTHER

☐Herpes 1 ☐Herpes 2 ☐Lymphogranuloma venereum

Form Rev. 4/2017

The diagnosis section of this form is reserved for STD, HIV and Hepatitis testing and treatment information. For new cases of chlamydia, gonorrhea, and syphilis site of infection and treatment information should be identified. Treatment information includes date treated and treatment regimen. In the case of co-infection, all diseases, diagnosis and treatment regimens should be listed.

Chlamydia

CHLAMYDIA

Positive specimen site (select all that apply):
☐Genital ☐Urine ☐Rectum
☐Pharynx ☐Other: _____

Date treated: / /
Treatment: ☐Azithromycin 1g ☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days
☐Other: _____

Was the patient offered Chlamydia-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____

1) Site:
   - Select the site or sites of infection for chlamydia
     - If the site is not listed, select other and write in the specific site

2) Date Treated:
   - Enter the date treatment was initiated

3) Treatment:
   - Select one of the available treatment options

- If other is selected, please enter the specific treatment regimen prescribed

4) Partner Medication/Prescriptions:
    - If expedited partner therapy (EPT) was offered or not, please indicate by checking the appropriate response of Yes or No
    - If you checked the response of Yes, please indicate the number of medications and/or prescriptions given to the patient for their partner(s).

Gonorrhea

GONORRHEA	
Positive specimen site (select all that apply): ☐Genital ☐Urine ☐Rectum ☐Pharynx ☐Other: _____	**Date treated**: / / **Treatment**: ☐Ceftriaxone 250mg IM ☐Azithromycin 1g ☐Cefixime 400mg PO ☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days ☐Gentamicin 240mg IM ☐Gemifloxacin 320mg PO ☐Other: _____
Was the patient offered Gonorrhea-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____	

1) Site:
    - Select the site or sites of infection for gonorrhea
        - If the site is not listed, select other and write in the specific site

2) Date Treated:
    - Enter the date treatment was initiated

3) Treatment:
    - Select one of the available treatment options
        - If other is selected, please enter the specific treatment regimen prescribed

4) Partner Medication/Prescriptions:
    - If expedited partner therapy (EPT) was offered or not, please indicate by checking the appropriate response of Yes or No
    - If you checked the response of Yes, please indicate the number of medications and/or prescriptions given to the patient for their partner(s).

Hepatitis B

HEPATITIS B (select all that were positive/reactive)			
☐HBsAg ☐HBsAb ☐HBcAb, Total ☐HBcAb, IgM	**Date Diagnosed**: / /	**Diagnosis type**: ☐Past ☐Current	**Vaccinated?** ☐
	Describe **symptoms**, if any: _____		

1) Test:
    - Select each applicable test

2) Date Diagnosed:
    - Enter the date the patient was diagnosed with Hepatitis B

3) Diagnosis Type:
    - Past- diagnosis occurred prior to the reporting of this document
    - Current- diagnosis occurred in conjunction with the reporting of this document

4) Vaccination:
    - Check the box if the patient was vaccinated for hepatitis B
        - If vaccination has not been provided, please leave it blank

5) Describe Symptoms:
    - Please document identified signs and symptoms reported in relation to Hepatitis B

Hepatitis C

HEPATITIS C	
(select all that were positive/reactive) ☐HCV Ab ☐HCV RNA	**Date Diagnosed**: / / **Diagnosis type**: ☐Past ☐Current **Treated?** ☐ Describe **symptoms**, if any: _____

1) Test:
    - Select each applicable test

2) Date Diagnosed:
    - Enter the date the patient was diagnosed (date of the positive test) with Hepatitis C

3) Diagnosis Type:
    - Past- diagnosis occurred prior to the reporting of this document
    - Current- diagnosis occurred in conjunction with the reporting of this document

4) Treatment:
    - Check the box if treatment has been provided for hepatitis C
        - If treatment has not been provided, please leave it blank

5) Describe Symptoms:
    - Please document identified signs and symptoms in relation to Hepatitis C

Human Immunodeficiency Virus (HIV)

HIV (check all that were positive/reactive)	
☐HIV Rapid Test ☐HIV-1/2 Ag/Ab ☐HIV-1/2 type differentiating ☐HIV-1 WB ☐HIV RNA or NAT **Diagnosis documented by a physician?** ☐Yes ☐No	**Date Diagnosed**: / / **Was client informed of HIV status?** ☐Yes ☐No ☐Unknown **Was client linked to HIV medical care?** ☐Yes ☐No ☐Unknown **If Yes, where linked?** _____ ☐Check if SAME as Reporting Facility **Did you verify client attended appointment for HIV care?** ☐Yes ☐No ☐Unknown

1) Test:
    - Select each applicable test

2) Physician Diagnosis:
    - Select Yes if laboratory evidence of an HIV diagnosis is unavailable and written documentation of lab evidence is consistent with the case definition
    - Otherwise select No.

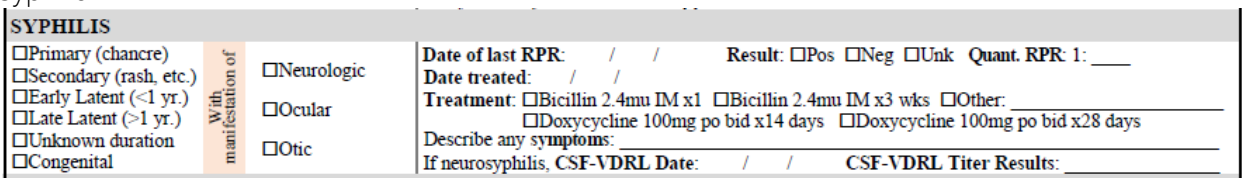
3) Date Diagnosed:
    - Enter the date the patient was diagnosed with HIV (earliest known positive date)

4) Patient Informed of Status:
    - Select the applicable response

5) Linked to Care:
    - Select the applicable response
        - If the client was linked to care, please enter the location
            - If the facility completing the form is the same as the diagnosing facility, Check the box indicating, SAME as the Reporting Facility

6) If you check Yes to the Linked to Care question, please check the appropriate response to whether or not the appointment to the care facility was verified by you, the reporting facility.

Syphilis



1) Stage at Diagnosis:
    - Select the most applicable stage at diagnosis

2) Syphilis associated manifestations:
    - Check the appropriate box if there were neurologic, ocular, or otic manifestations with the syphilis infection

3) Date of last RPR
    - Please document the date of the latest RPR on record

4) Result of the last RPR
    - If the RPR was qualitative, please check the appropriate result or Pos, Neg, or Unk
    - If the RPR was quantitative, please provide the dilution value

5) Date Treated:
    - Enter the date treatment was initiated

6) Treatment:
    - Select one of the available treatment options
        - If other is selected, please enter the specific treatment regimen prescribed

7) Describe Symptoms:
    - Please enter all symptoms reported by the patient in relation to syphilis

8) Neurosyphilis:
    - If the patient is diagnosed as having neurosyphilis, please enter the date and result of their diagnosing CSF-VDRL

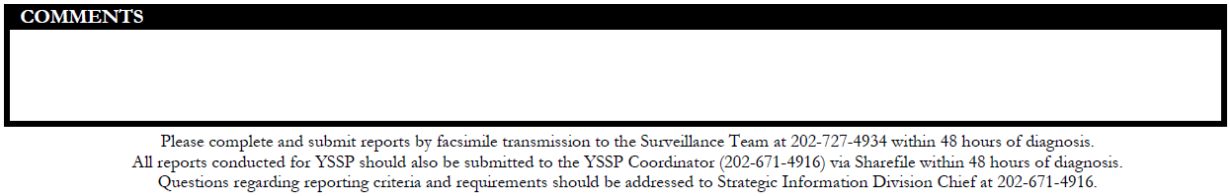
Other


OTHER

☐Herpes 1 ☐Herpes 2 ☐Lymphogranuloma Venereum

This section is for patients diagnosed with Herpes 1, Herpes 2 or Lymphogranuloma Venereum. All other Sexually Transmitted Disease or co-infections such as pelvic inflammatory disease, trichomoniasis etc., should be noted in the 'comments' section of this form

Section 5: Comments


COMMENTS

Please complete and submit reports by facsimile transmission to the Surveillance Team at 202-727-4934 within 48 hours of diagnosis.
All reports conducted for YSSP should also be submitted to the YSSP Coordinator (202-671-4916) via Sharefile within 48 hours of diagnosis.
Questions regarding reporting criteria and requirements should be addressed to Strategic Information Division Chief at 202-671-4916.

This section is reserved for any comments the provider or reporter would like to leave for the surveillance team. Examples of comments include: more information detailing risk behavior staff should know about immediately, the reporting of preliminary positive tests, alternate addresses or information that requires immediate follow up. Those who are participating in the Counseling, Testing, and Referral program should also document the EvaluationWeb ID number.

Appendix A- Notifiable Disease Report Form Quick Reference

Question	Description	Example
Section 1: Health Provider Information		
Reporting Facility Name	The full name of the facility that ran tests for and diagnosed HIV status.	Wellness Clinic of DC
Date Form Completed	The date the form is being completed. This date should be filled even if it is sent at a later time.	5/1/2016
Person Completing Form	The person completing the physical form.	Dr. John Smith
Phone	The 10 digit telephone number to reach the person completing the form.	(202) 202-2002
Program	The program under which the test was conducted	CTR
Street Address	The street address of the facility completing the form.	1000 Main Street NW
City	The city where of the facility completing the form.	Washington
County/Ward	Depending on the state, signify the county and/or here.	Montgomery County or Ward 4
State/Country	The state and country of the facility completing the form.	DC/USA
Zip code	The zip code of the facility completing the form.	20002
Section 2: Patient Demographics		
Last Name	The surname given at birth.	Doe
First Name	The first name given at birth.	John
Date of birth	The date in which the patient was born.	01-01-1980
Social Security Number	The entire or partial social security number of the patient.	987-65-1234
Medical Record Number	The number associated with the patient's record.	RN54321
Address type:	*Residential*: The address where the patient resides. *Correctional*: Check this box if the patient is currently residing within a correctional facility. *Foster Home*: Check this box if the patient is residing in a foster home. *Homeless*: Check this box if the patient does not have a physical address in which they reside. *Postal*: Check this box if a postal box address is given. *Shelter*: Check this box if the patient is currently residing in a shelter home.	1000 Main Street NW Washington, DC 20002

	Temporary: Check this box if the address given is not a permanent address. (Ex. patient living with friend, away at college or with a family member) *Bad/Invalid Address*: the address provided by the patient does not exist. The DC Master Address Repository can be searched for valid District of Columbia addresses: http://dcatlas.dcgis.dc.gov/mar/.	
Current Street Address	The number and name of the street where the patient resides.	1111 Main Street NW
Apt. Number	The apartment number where the patient resides.	Apt. #3
Phone	The 10 digit telephone number to reach the patient.	202-222-2222
City	The city where of the patient resides.	Washington
County/Ward	Depending on the state, signify the county and/or here.	Howard County/7
State/Country	The state and country where the patient resides.	DC/USA
Zip Code	The zip code where the patient resides.	21121
Emergency Contact	The name of a person who should be contacted in the case of an emergency situation.	Jack Doe, Father
Emergency Contact Telephone	The telephone number of the person who should be contacted in the case of an emergency situation.	212-222-2221
Sex at Birth	Assigned sex at the time of birth.	Female or Male.
If female, pregnant?	Female patients currently pregnant.	No.
Current Gender	*Male*: Having male genitals at birth. *Female*: Having female genitals at birth. *Transgender Female*: Having male genitals at birth and currently identifying as female gender. *Transgender Male*: Having female genitals at birth and currently identifying as male gender. *Unknown*: No status of gender was confirmed for the patient.	Male
Ethnicity	Hispanic/Latino Hot Hispanic/Latino Unknown	Hispanic
Race	*White*: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	Check the Black and White boxes on form

	Black or African American: A person having origins in any of the Black racial groups of Africa. *American Indian or Alaska Native*: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. *Asian*: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Native Hawaiian or Other Pacific Islander*: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *Other*: A person having multiple origins or race	if the patient has biracial origins.
Was the patient notified that they will be contacted by DOH partner services?	The patient was notified and understands that they will be contacted by DOH partner services following the	Yes OR No
Is the patient on PrEP?	The patient was prescribed Pre-exposure prophylaxis medication at the time of diagnosis. The patient was not prescribed Pre-exposure prophylaxis medication at the time of diagnosis.	Yes OR No
Section 3: Patient Medical Information/History		
Date of Exam	The date the patient was administered the exam.	5/16/2016
Reason for Exam	The reason the patient entered your facility to undergo services.	Annual STD testing.
Section 4: Diagnosis		
Chlamydia		
Site	The site of infection for chlamydia.	Urethra
Date treated	The date the patient received medication/treatment services.	05/16/2016
Treatment	The name of the treatment regimen prescribed to the patient.	Azithromycin 1g
How many medications/prescriptions was the patient given for their partners	The number of medications/prescriptions the patient was given for their partners. Medications/prescriptions were no offered to the patient to give to their partners.	2 Not offered
Gonorrhea		

Site	The site of infection for gonorrhea.	Cervix
Date treated	The date the patient received medication/treatment services.	05/16/2016
Treatment	The name of the treatment regimen prescribed to the patient.	Ceftriaxone 250mg IM AND Azithromycin 1g
How many medications/prescriptions was the patient given for their partners	The number of medications/prescriptions the patient was given for their partners. Medications/prescriptions were not offered to the patient to give to their partners.	0 Not offered
Hepatitis B		
Surface Antigen (HBsAG)	An antigen test to determine early signs of an active hepatitis B infection.	√ or leave blank
Surface antibody (anti-HBs)	An antibody test to determine the presence of antibody and the need for vaccination was administered.	√ or leave blank
Date Diagnosed	Date patient received positive confirmatory test results.	5/16/2016
Diagnosis type	The current or past status of Hepatitis B occurrence.	Past
Treatment	The status of whether the treatment occurred.	Yes
Describe symptoms, if noted	The physical or mental feature that is appears apparent on the patient indicating a condition of Hepatitis B.	Abdominal pain
Hepatitis C		
Anti HCV Screening Test	A test used to detect antibodies to the hepatitis C virus, indicating exposure was administered.	√ or leave blank
Anti HCV RIBA	A confirmation test for the hepatitis C antibody was administered.	√ or leave blank
Anti HCV RNA	A qualitative test used to distinguish between a current or past HCV infection was administered.	√ or leave blank
Date Diagnosed	Date patient received positive confirmatory test results.	5/16/2016
Diagnosis type	The current or past status of Hepatitis B occurrence.	Current
Treatment	The status of whether the treatment occurred.	Yes
Describe symptoms, if noted	The physical or mental feature that is appears apparent on the patient indicating a condition of Hepatitis C.	Abnormalities in urine
HIV		
HIV-1/2 Ag/Ab	A HIV-1/2 Ag/Ab combo immunoassay or 4th generation test was administered.	Check the HIV-1/2 Ag/Ab box.
HIV-1/2 Differentiating (e.g., Multispot)	A HIV-1/HIV-2 antibody differentiation immunoassay or Multispot test was administered.	Check the HIV-1/2 Differentiating (e.g., Multispot) box.
HIV-1 WB	A HIV-1 Western blot was administered.	Check the HIV-1 WB box.

Diagnosis documented by a physician?	The patient had the diagnosis of HIV documented by a physician at your facility.	Yes
Date diagnosed	Date patient received positive confirmatory test results.	5/16/2016
Was the patient informed of HIV status?	The patient notification status of their HIV status.	Yes OR No
Was patient linked to HIV medical care?	The patient was or was not linked to HIV medical care.	Yes OR No
Linked, where?	Name of facility where patient was linked to medical care.	Wellness Center of DC
Not, why?	In the case the patient was not linked to medical care after diagnoses list the reason.	Declined HIV Care.
Syphilis		
Primary (chancre)	The presence of one or multiple chancre sores.	√ or leave blank
Secondary (rash, etc.)	The presence of skin rashes and/or sores in the mouth, vagina, or anus.	√ or leave blank
Early Latent (<1 year duration but no symptoms)	Less than one year duration but no symptoms are present, begins when primary and secondary symptoms disappear	√ or leave blank
Late Latent (>1 year duration but no symptoms)	Late latent: more than one year duration but no symptoms present.	√ or leave blank
Unknown duration	The duration of the infection is unknown.	√ or leave blank
Congenital	Occurs when syphilis is passed from mother to child during fetal development or at birth.	√ or leave blank
Neurosyphilis	The syphilis invasion of the nervous system.	Yes OR No
Date treated	The date the patient received medication/treatment services.	5/16/2016
Treatment	The name of the treatment regimen prescribed to the patient.	Bicillin 2.4mu IMx1
Date of Last RPR	The date of the last Rapid Plasma Reagin test.	05/16/2016
Result	The positive or negative result of the Rapid Plasma Reagin test.	Positive
Describe symptoms, if noted	The physical or mental feature that is appears apparent on the patient indicating a condition of syphilis.	Small chancre in rectum.
Other		
Herpes 1	Sexually transmitted infection causing sores around mouth and lips. Can also cause genital herpes.	√ or leave blank
Herpes 2	Sexually transmitted infection that causes genital herpes.	√ or leave blank
Lymphogranuloma Venereum	A long-term (chronic) infection of the lymphatic system caused by any of 3 different types of the bacteria Chlamydia trachomatis.	√ or leave blank