INSTRUCTIONS FOR COMPLETING
THE
DISTRICT OF COLUMBIA
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT FORM
July 2007

The District of Columbia Adult HIV/AIDS Confidential Case Report Form is the District's version of the CDC Adult HIV/AIDS Case Report Form, and as of the date of its release, replaces all prior HIV and AIDS case report forms used in the District for patients age 13 and over. (A separate form is used for reporting HIV/AIDS in patients under age 13.) Instructions for each section of the form are found below. Additional copies of the form and expanded instructions can be obtained by calling the Department of Health (DOH), HIV/AIDS Administration, Bureau of Surveillance and Epidemiology, at (202) 671-4900 or by visiting the HIV/AIDS website at www.doh.dc.gov.

The adult case report form should be completed for all patients with evidence of HIV infection or an AIDS diagnosis, and returned to the Bureau of Surveillance and Epidemiology within 48 hours of confirmation of diagnosis. Patients for whom this form is indicated include the following patients 13 years of age or older:

- Patients with an HIV (not AIDS) diagnosis
- Patients with an AIDS diagnosis
- Patients who were previously reported with HIV (not AIDS) and who have progressed to AIDS
- Patients who are HIV infected or who have AIDS and have died.

SECTION I. FOR HEALTH DEPARTMENT USE ONLY
Please leave blank all of the gray-shaded areas marked for "Health Department Use Only".

SECTION II. PATIENT INFORMATION FOR HIV AND AIDS
Patient identifier information is not transmitted to CDC; however, all information in this section must be completed.

Check the appropriate box under diagnostic status whether you are reporting HIV infection (not AIDS) or AIDS. All information that follows should reflect when HIV or AIDS was first diagnosed. Enter the patient's full name, social security number, current telephone number and address, and, if available, any aliases.

Note: DOH encourages providers to explain to their patients that strict procedures are in place to protect the confidentiality and security of all information collected on the HIV/AIDS Case Report Form. DOH does not transmit names, social security numbers, or other information that could be used to identify an individual to the Federal Government; nor

release any information that could be used to identify an individual to any other agency, business, or individual. All data is reported in the aggregate, in summary tables, charts, and graphs. Nonetheless, some patients may not wish to provide their social security number. In this circumstance, DOH encourages providers to complete the case report form to the best of their ability, providing the patient's name, date of birth, and other identifying information requested on the form. This will assist DOH in maintaining accurate, unduplicated records, an essential element of our quality assurance procedures.

Note: 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.

SECTION III. REPORTING INFORMATION
Enter the name of the facility and the city, state, and telephone number of the facility where the patient was first diagnosed as HIV positive or with AIDS.

SECTION IV. PATIENT HISTORY
Check ALL boxes that apply.

Indicate dates of first and last blood transfusion if applicable.

Write in the specific occupation if the patient is, or was, a healthcare worker.

SECTION V. LABORATORY DATA
Please indicate the first documented HIV positive result at your facility for the patient. Include EIA and Western blot antibody tests, viral loads, and other positive virus detection tests.

If laboratory documentation of a positive HIV test is unavailable in the medical record, enter the date of physician diagnosis of HIV infection. A physician diagnosis is made by clinical 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.

Under the provider identifier information section, list the medical record number of the patient if available.

SECTION VI. REASON FOR VISIT
Indicate the reason for the patient's visit and mark all reasons that apply. Indicate any additional risk information, including co-infections and diagnosis dates for these infections.

SECTION VII. CLINICAL STATUS
Please indicate whether the clinical record was reviewed. For AIDS reports, check all known indicator diseases and enter dates of diagnosis. Specify whether diagnoses are presumptive or definitive. (Definitive diagnoses are generally based upon specific laboratory methods, while presumptive diagnoses are those made by a clinician).

SECTION VIII. TREATMENT SERVICES AND REFERRALS
For women only -- Please indicate whether the patient is currently pregnant and list her anticipated due date. Provide birth information for the most recent birth, if applicable, and the number of live-born children delivered since diagnosis.

Please leave blank all of the gray-shaded areas marked for "Health Department Use Only".

Complete all partner services questions including "has the patient been informed of their HIV infection and who will counsel the patient's partners about their HIV exposure".

SECTION IX. HIV TESTING HISTORY
HIV testing and treatment history information must be completed for all new HIV/AIDS reports in the District of Columbia. Dates are very important for this section. Enter patient-reported answers to questions about past testing behaviors and the dates of these tests as reported by the patient. If the patient received medication to treat or prevent HIV, enter medication names and start/end dates as applicable. This information will be used in the calculation of HIV incidence rates (rates of recent infection).

SECTION X. FOR HEALTH DEPARTMENT USE ONLY
Please leave blank all of the gray-shaded areas marked for "Health Department Use Only".

SECTION X1. COMMENTS SECTION
Please add any additional laboratory, clinical, partner counseling and referral service, or other relevant information here.

MAILING / DELIVERY INSTRUCTIONS

Completed case report forms should be mailed in a double-sealed envelope marked **"CONFIDENTIAL"** to:

Department of Health
Box 19 - Attn. Field Coordinator
64 New York Avenue, N.E.
Washington, DC 20002

Alternatively, completed reports may be hand delivered to:

Attn: Field Coordinator
Bureau of Surveillance and Epidemiology
HIV/AIDS Administration
Department of Health
64 New York Avenue, N.E., Suite 5001
Washington, D.C. 20002