

New Jersey Department of Health and Senior Services
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(FOR PATIENTS ≥ 13 YEARS OF AGE AT TIME OF DIAGNOSIS)

Date Received at NJDHSS

(IMPORTANT: Fields which are "shaded" are required fields and MUST be completed.)

PATIENT NAME AND ADDRESS				
Patient Name (Last, First, MI)		Alias		Telephone No.
Address		City		State Zip Code
County	Date Form Completed	Prisoner Number	CTS Number	Medical Record Number

NJDHSS USE ONLY	
Soundex Code	Reporting Health Department-State State Patient Number
Surveillance Method <input type="checkbox"/> A <input type="checkbox"/> F <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> U	Reporting Health Department-City/County
Document Source	Or Source Code A
Did this Report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Report Medium <input type="checkbox"/> Field Visit <input type="checkbox"/> Mailed <input type="checkbox"/> Telephone <input type="checkbox"/> SDN

DEMOGRAPHIC INFORMATION				
Diagnostic Status at Report <input type="checkbox"/> HIV Infection (not AIDS) <input type="checkbox"/> AIDS	Date of Birth (Month/Day/Year) _ / _ / _	Alias Date of Birth (Month/Day/Year) _ / _ / _	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Country of Birth <input type="checkbox"/> U.S. <input type="checkbox"/> Other, Specify:
Ethnicity (Select One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown	Race (Select one or more) <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pac. Isl. <input type="checkbox"/> Unknown			
Current Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead	Date of Death _ / _ / _	State/Territory of Death		

RESIDENCE AT DIAGNOSIS			
City	County	State/Country	Zip Code _ - _ - _

FACILITY/PROVIDER OF DIAGNOSIS			
Name of Facility/Provider		Name of Contact Person	
Facility/Provider Full Address		Name of Person Completing Form	
City	State	Zip Code	Main Telephone Number
Facility Setting (Check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Unknown		Facility Type (Check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other, Specify:	

PATIENT HISTORY							
Yes	No	Unk		Yes	No	Unk	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received clotting factor for hemophilia/coagulation disorder - specify disorder: <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other, Specify:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transfusion of blood/blood components (other than clotting factor) First (Mo/Yr): _ / _ Last (Mo/Yr): _ / _
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injected nonprescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transplant of tissue/organs or artificial insemination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HETEROSEXUAL relations with any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worked in a health-care or clinical laboratory setting; -specify occupation:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous/injection drug user				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bisexual male				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Person with hemophilia/coagulation disorder				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion recipient with documented HIV infection				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplant recipient with documented HIV infection				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Person with AIDS or documented HIV infection, risk not specified				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perinatal infection				

CLINICAL STATUS			
Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Co-Infection: <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> STD (Specify): _____	Date Patient was Diagnosed as Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): _ / _	Date Patient was Diagnosed as Symptomatic (not AIDS): _ / _

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT (Continued)

LABORATORY DATA

HIV Antibody Tests at Diagnosis

HIV-1 Western Blot Pos Neg / /
 Rapid _____ Pos Neg / /
 Rapid _____ Pos Neg / /
 HIV-1 EIA Pos Neg / /
 HIV-1/2 EIA Pos Neg / /
 HIV-2 EIA Pos Neg / /
 HIV-2 Western Blot Pos Neg / /

Positive HIV Detection Test (Record Earliest Test)

Culture Antigen PCR, DNA or RNA probe / /
Other (Specify): _____ / /

Viral Load Test (Earliest and Most Recent Tests)

Test Type	Copies/ml or Undetectable	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> NASBA	_____	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> RT-PCR	_____	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> bDNA	_____	<u> / / </u>	<u> / / </u>
Test Type	Copies/ml or Undetectable	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> NASBA	_____	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> RT-PCR	_____	<u> / / </u>	<u> / / </u>
<input type="checkbox"/> bDNA	_____	<u> / / </u>	<u> / / </u>

Date of last documented Negative HIV test (specify type): / /
 IF HIV lab tests were not documented, is HIV diagnosis documented by a physician? Yes No Unk.
 If yes, provide date of documentation by physician: / /

Prior Tests

No. of HIV tests in 2 years before first positive: _____

Immunologic Lab Tests

At or closest to current diagnostic status:
 CD4 Count cells/ μ L / /
 CD4 Percent % / /
 First <200 μ L or 14%
 CD4 Count cells/ μ L / /
 CD4 Percent % / /

Genotype Testing

Yes No Lab: _____ Date: / /

AIDS INDICATOR DISEASES

AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)	AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)
	Def.*	Pres.*			Def.*	Pres.*	
Candidiasis, bronchi, trachea, or lungs		N/A	<u> / </u>	Lymphoma, Burkitt's (or equivalent term)		N/A	<u> / </u>
Candidiasis, esophageal			<u> / </u>	Lymphoma, immunoblastic (or equivalent term)		N/A	<u> / </u>
Carcinoma, invasive cervical		N/A	<u> / </u>	Lymphoma, primary in brain		N/A	<u> / </u>
Coccidioidomycosis, disseminated or extrapulmonary		N/A	<u> / </u>	<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary			<u> / </u>
Cryptococcosis, extrapulmonary		N/A	<u> / </u>	<i>M. tuberculosis</i> , pulmonary **			<u> / </u>
Cryptosporidiosis, chronic intestinal (>1 mo. Duration)		N/A	<u> / </u>	<i>M. tuberculosis</i> , disseminated or extrapulmonary **			<u> / </u>
Cytomegalovirus disease (other than in liver, spleen, or nodes)		N/A	<u> / </u>	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary			<u> / </u>
Cytomegalovirus retinitis (with loss of vision)		N/A	<u> / </u>	<i>Pneumocystis carinii</i> pneumonia			<u> / </u>
HIV encephalopathy		N/A	<u> / </u>	Pneumonia, recurrent, in 12 mo. Period			<u> / </u>
Herpes simplex: chronic ulcer(s) (>1 mo. Duration), or bronchitis, pneumonitis or esophagitis		N/A	<u> / </u>	Progressive multifocal leukoencephalopathy		N/A	<u> / </u>
Histoplasmosis, disseminated or extrapulmonary		N/A	<u> / </u>	Salmonella septicemia, recurrent		N/A	<u> / </u>
Isosporiasis, chronic intestinal (>1 mo. Duration)		N/A	<u> / </u>	Toxoplasmosis of brain			<u> / </u>
Kaposi's sarcoma			<u> / </u>	Wasting syndrome due to HIV		N/A	<u> / </u>

* Def. = Definitive Diagnosis Pres. = Presumptive Diagnosis ** RVCT Case No.: _____

TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of patient's sex or needle sharing partners: _____	Number of patient's partners notified about their HIV exposure by provider: _____
Is this patient receiving or has been referred for: HIV related medical services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	This patient received or is receiving: Antiretroviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Substance abuse treatment services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	PCP prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
This patient has been enrolled at (clinical trial)? <input type="checkbox"/> NIH Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	This patient has been enrolled at (clinic)? <input type="checkbox"/> HRSA Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
At time of HIV/AIDS diagnosis, medical treatment primarily reimbursed by: <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		

FOR MEN:

Is this patient circumcised?
Yes No Unknown
 If Yes, patient's age at circumcision: _____

FOR WOMEN:

This patient is receiving or has been referred for gynecological or obstetrical services: Yes No Unknown
 Is this patient currently pregnant? Yes No Unknown
 Has this patient delivered live-born infants since 1989? Yes (If yes, provide birth information below.) No Unknown

Child's DOB (Mo/Day/Yr.)	Name of Child	Hospital	City	State	Child's Soundex	Child's State No.

Comments