WASHINGTON STATE CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

phone: 509.324.1544
fax: 509.324.1468

PATIENT INFORMATION

Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #: | Social Security #:

Email:

Current Street Address: | Date Address Verified:

City: | Zip Code: | ☐ Alive ☐ Dead

Birthdate (mm/dd/yyyy) | Death date (mm/dd/yyyy) | State of death:

Sex at birth:
☐ Male
☐ Female

Current gender identity:
☐ Woman ☐ Trans Woman
☐ Man ☐ Trans Man
☐ Non-Binary ☐ Genderqueer
☐ Other____________________

Ethnicity:
☐ Hispanic
☐ Not Hispanic
☐ Other___________
(Refer to Supplemental List on p.3)

Marital Status:
☐ Married ☐ Never married
☐ Separated ☐ Unknown
☐ Divorced
☐ Widowed

Race (check all that apply):
☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black ☐ American Indian/Alaska Native
☐ Asian
☐ Other(s)______________________________
(Refer to Supplemental List on p.3)

Country of birth: ☐ U.S. ☐ Other: ______________________

If other, date of entry into U.S.:

Primary Language: ☐ English ☐ Other: ________________________
(Refer to Supplemental List on p.3)

Was the patient dx in another state or country? ☐ Yes ☐ No

If yes, specify state or country: ______________________________

Residence at time of **HIV** diagnosis if different than current address:

Residence at time of **AIDS** diagnosis (if applicable) if different than current address:

Medical Record # Patient Code:

FACILITY AND PROVIDER INFORMATION

Name and City of facility of **HIV** diagnosis:

____

☐ Outpatient diagnosis[2] ☐ Inpatient diagnosis ☐ ER diagnosis

Name and City of facility of **AIDS** diagnosis (if applicable):

____

☐ Outpatient diagnosis[2] ☐ Inpatient diagnosis ☐ ER diagnosis

Provider of **HIV** Diagnosis:

Provider of **AIDS** Diagnosis (if applicable):

Person reporting: | Phone:

Facility reporting if other than facility of diagnosis:

STATE HEALTH DEPARTMENT USE ONLY

☐ HIV	☐ AIDS	Stateno:_______________
Date: __________________		Source: _______________
☐ New case	☐ Progression	☐ Update, no status change

HIV DIAGNOSTIC TESTS

Type of Test *At least 2 antibody tests must be indicated for an HIV diagnosis* IA = Immunoassay	**Collection date**	Rapid test	**Result** (check one per row): Positive/ Reactive	Indeterminate	Negative/ Non-Reactive
Last Negative Test (prior to HIV diagnosis)	_________				
HIV-1/2 Ag/Ab IA (4th Gen)	_________				
HIV-1/2 EIA IA (2nd or 3rd Gen)	_________				
HIV 1 and 2 Type Differentiating IA (Supplemental Ab Test)	_________		☐ HIV-1 ☐ HIV-2 ☐ Undiff	☐ HIV-1 ☐ HIV-2	☐ HIV-1 ☐ HIV-2
HIV-1 Western Blot	_________				
HIV-1 RNA/DNA Qualitative NAAT	_________				
OTHER: ________________________	_________				

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider?

☐ Yes → Date of documentation by care provider: ______________
☐ No
☐ Unknown

HIV CARE TESTS[4]

HIV VIRAL LOAD TESTS

	Test Date	Copies/ml
Earliest HIV viral load	______________	__________
Most recent HIV viral load	______________	__________

EARLIEST DRUG RESISTANCE TEST

Date: ☐ Genotype ☐ Phenotype

Laboratory:______________________

CD4 LEVELS

	Test Date	Count	%
Earliest CD4	______________	________cells/µl	_____%
Most recent CD4	______________	________cells/µl	_____%
First CD4 <200 µl	______________	________cells/µl	_____%

PATIENT HISTORY SINCE 1977[3]

Check all that apply:	Yes	No	Unk
Sex with male……	☐	☐	☐
Sex with female……	☐	☐	☐
Person who injects drugs……	☐	☐	☐
Received clotting factors for hemophilia……	☐	☐	☐
Transfusion, Transplant, or Insemination……	☐	☐	☐
Perinatal Transmission…… (Biological mother known HIV+)	☐	☐	☐

Heterosexual relations with:	Yes	No	Unk
Person who injects drugs…	☐	☐	☐
Bisexual man……	☐	☐	☐
Person with hemophilia……	☐	☐	☐
Person living w/ HIV……	☐	☐	☐

Other Risk(s): ______________________

OPPORTUNISTIC ILLNESSES[4,5]

	Diagnosis date		Diagnosis date
☐ Candidiasis, esophageal	___________	☐ Kaposi's sarcoma	___________
☐ Cryptococcosis, extrapulmonary	___________	☐ PCP/PJP (Pneumocystis pneumonia)	___________
☐ Cytomegalovirus disease (other than in liver, spleen, nodes)	___________	☐ Wasting syndrome due to HIV	___________
☐ Herpes simplex: chronic ulcer(s) (>1 mo. duration) bronchitis, pneumonitis or esophagitis	___________	☐ Other(s): ______________________	___________

Please return completed form to:

Spokane Regional Health District
HIV/STI Prevention Program

Phone: 509-324-1544
Fax: 509-324-1468

Scan code to access footnotes, reporting requirements, and lists found on page 3.

HIV TESTING AND TREATMENT HISTORY

Date patient reported info: __________ Information from: ☐ Patient interview ☐ Review of medical record ☐ Provider report ☐ PEMS ☐ Other

FIRST POSITIVE HIV TEST	NEGATIVE HIV TESTS
Ever had a previous positive test? ☐ Yes ☐ No ☐ Unknown	Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown
Date of first positive test: ______________	Date of last negative test: ______________
	Number of negative HIV tests in 24 months before first positive test:____________

HISTORY OF HIV-RELATED MEDICATIONS **(check all that apply)**

Ever taken any antiretroviral medications (ARVs)? ☐ Yes ☐ No ☐ Unknown

Reason	Name(s) of medication(s)	Date began	Currently Taking?	Date of last use (if no longer taking):
☐ HIV Treatment.......	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
	☐ ______________________	_________	☐ Yes	_________
☐ PREP.......................	☐ ______________________	_________	☐ Yes	_________
☐ PEP	☐ ______________________	_________	☐ Yes	_________
☐ PCP Prophylaxis..	☐ Bactrim ☐ Other__________	_________	☐ Yes	_________
☐ Other ARV............	☐ ______________________	_________	☐ Yes	_________

DRUG USE

Methamphetamine use? ☐ No ☐ Unknown
☐ Yes → ☐ Injection ☐ Non-injection, specify: __________ ☐ Unk

TREATMENT/SERVICES REFERRALS

	Yes	No	Unk	N/A
Has this patient been informed of his/her HIV status?...............	☐	☐	☐	
This patient is receiving/has been referred for:				
▪ HIV related medical service......................................	☐	☐	☐	
▪ HIV Social Service Case Management.........................	☐	☐	☐	
▪ Substance abuse treatment services..........................	☐	☐	☐	☐

FOR WOMEN

Is patient currently pregnant?
☐ No
☐ Unknown
☐ Yes→ Expected delivery date:
____

COMMENTS

FOR STATE HEALTH DEPARTMENT USE ONLY

eHARS FORM INFO

STATENO: Date received:

Document Source: ☐ Inpatient ☐ Outpatient ☐ ER ☐ Other:_____________

Did this document initiate a new investigation?: ☐ Yes ☐ No

Report Medium: ☐ Paper, field ☐ Paper, fax ☐ Paper, mail ☐ Phone ☐ Electronic

Surveillance Method: ☐ Active ☐ Passive ☐ Follow-Up

Date form completed: ________________________

Case report completed by:
Phone:

Facility completing form:

LOCAL FIELDS

Transgender? ☐ FM ☐ MF ☐ Other:
Additional Gender Identity:

LHJ Notification Date:
LHJ Notification County:

SOUNDEX

Last Name Soundex(s): ________________
☐ CDC Soundex check complete ☐ No Soundex matches
Soundex Matches/Duplicate Review:

Comments:

FOOTNOTES

[1] Patient identifier information is not sent to CDC.

[2] Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc. Inpatient dx: diagnosed during a hospital admission of at least one night.

[3] After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.

[4] If case progresses to AIDS, please notify health department.

[5] Opportunistic illnesses include: Candidiasis, bronchi, trachea, or lungs; Candidiasis, esophageal; Cervical cancer, invasive; Coccidioidomycosis, disseminated or extrapulmonary; Cryptococcosis, extrapulmonary; Cryptosporidiosis, chronic intestinal; Cytomegalovirus disease (other than liver, spleen, or nodes); Cytomegalovirus retinitis (with loss of vision); HIV encephalopathy; Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis; Histoplasmosis, diss. or extrapulmonary; Isosporiasis, chronic intestinal; Kaposi's sarcoma; Lymphoma, Burkitt's (or equivalent); Lymphoma, immunoblastic (or equivalent); Lymphoma, primary in brain; Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary; M. tuberculosis, pulmonary; M. tuberculosis, diss. or extrapulmonary; Mycobacterium of other or unidentified species, diss. or extrapulmonary; Pneumocystis pneumonia; Pneumonia, recurrent; Progressive multifocal leukoencephalopathy; Salmonella septicemia, recurrent; Toxoplasmosis of brain; Wasting syndrome due to HIV

WASHINGTON STATE REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

ASSURANCES OF CONFIDENTIALITY AND EXCHANGE OF MEDICAL INFORMATION

Several Washington State laws pertain to HIV/AIDS reporting requirements. These include: Maintain individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protect patient identifying information, meet published standards for security and confidentiality if retaining names of those with asymptomatic HIV, (WAC 246-101-230,520,635); investigate potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246- 101-520) and not disclose HIV/AIDS identifying information (WAC 246-101-120,230,520,635 and RCW 70.24.105).

Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).

Anyone who violates Washington State confidentiality laws may be fined a maximum of $10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

FOR PARTNER NOTIFICATION INFORMATION

Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).

For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call Infectious Disease Prevention Section Field Services, DOH, at (360) 236-3482 or (360) 236-3484, or your local health department. In King County, please call Public Health Seattle & King County, at (206) 263-2410.

For questions please contact:

Spokane Regional Health District

509-324-1544

or

Washington State Department of Health
Office of Infectious Disease
Assessment Unit

(360) 236-3464

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To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

ETHNICITY

A) Hispanic, Latino/a, Latinx
B) Non-Hispanic, Latino/a, Latinx
C) Patient declined to respond
D) Unknown

PREFERRED LANGUAGE

A) Amharic
B) Arabic
C) Balochi/Baluchi
D) Burmese
E) Cantonese
F) Chinese
G) Chamorro
H) Chuukese
I) Dari
J) English
K) Farsi/ Persian
L) Fijian
M) Filipinio/Pilipino
N) French
O) German
P) Hindi
Q) Hmong
R) Japanese
S) Karen
T) Khmer/Cambodian
U) Kinyarwanda
V) Korean
W) Kosraean
X) Lao
Y) Mandarin
Z) Marshallese
AA) Mizteco
BB) Nepali
CC) Oromo
DD) Panjabi/Punjabi
EE) Pashto
FF) Portuguese
GG) Romanian/Rumanian
HH) Russian
II) Samoan
JJ) Sign Language
KK) Somali
LL) Spanish/Castilian
MM) Swahili/Kiswahili
NN) Tagalog
OO) Tamil
PP) Telugu
QQ) Thai
RR) Tigrinya
SS) Ukrainian
TT) Urdu
UU) Vietnamese
VV) Other languages
WW) Patient declined to respond
XX) Unknown

RACE

A) Afghan
B) Afro-Caribbean
C) Alaska Native
D) American Indian
E) Arab
F) Asian
G) Asian Indian
H) Bamar/Burman.Burmese
I) Bangladeshi
J) Bhutanese
K) Black or African American
L) Central American
M) Cham
N) Chicano/a or Chicanx
O) Chinese
P) Congolese
Q) Cuban
R) Dominican
S) Egyptian
T) Eritrean
U) Ethiopian
V) Fijian
W) Filipino
X) First Nations
Y) Guamanian or Chamorro
Z) Hmong/Mong
AA) Indigenous– Latino/a. Latinx
BB) Indonesian
CC) Iranian
DD) Iraqi
EE) Japanese
FF) Jordian
GG) Karen
HH) Kenyan
II) Khmer/Cambodian
JJ) Korean
KK) Kuwaiti
LL) Lao
MM) Lebanese
NN) Malaysian
OO) Marshallese
PP) Mestizo
QQ) Mexican/Mexican American
RR) Middle Eastern
SS) Mien
TT) Morrocan
UU) Native Hawaiian
VV) Nepalese
WW) North African
XX) Oromo
YY) Pacific Islander
ZZ) Pakistani
AAA) Puerto Rican
BBB) Romanian/ Rumanian
CCC) Russian
DDD) Samoan
EEE) Saudi Arabian
FFF) Somali
GGG) South African
HHH) South American
III) Syrian
JJJ) Taiwanese
KKK) Thai
LLL) Tongan
MMM) Ugandan
NNN) Ukranian
OOO) Vietnamese
PPP) White
QQQ) Yemeni
RRR) Other Race
SSS) Patient declined to answer
TTT) Unkown