

CLINICAL AIDS

Disease	Diagnosis Date (mm/dd/yyyy)	dx method ⁵	
		Presumptive	Definitive
Candidiasis, bronchi, trachea, or lungs	__/__/__		<input type="checkbox"/>
Candidiasis, esophageal	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	__/__/__		<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	__/__/__		<input type="checkbox"/>
Cryptococcosis, extrapulmonary	__/__/__		<input type="checkbox"/>
Cryptosporidiosis, chronic ⁶ intestinal	__/__/__		<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	__/__/__		<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	__/__/__		<input type="checkbox"/>
Herpes simplex: chronic ⁶ ulcers; or bronchitis, pneumonitis, or esophagitis	__/__/__		<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	__/__/__		<input type="checkbox"/>
Isosporiasis, chronic ⁶ intestinal	__/__/__		<input type="checkbox"/>
Kaposi's sarcoma	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	__/__/__		<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	__/__/__		<input type="checkbox"/>
Lymphoma, primary in brain	__/__/__		<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis pneumonia	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent ⁷	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	__/__/__		<input type="checkbox"/>
Salmonella septicemia, recurrent	__/__/__		<input type="checkbox"/>
Toxoplasmosis of brain	__/__/__	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV ⁸	__/__/__		<input type="checkbox"/>

Return completed form to:



**Infectious Disease and Reproductive Health
Assessment Unit
PO Box 47838
Olympia, Washington 98504-7838
(360) 236-3409 or Toll Free: 888-367-5555**

FOOTNOTES

- ¹Patient identifier information is not sent to CDC.
- ²Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.
Inpatient dx: diagnosed during a hospital admission of at least one night.
- ³After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
- ⁴If case progresses to AIDS, please notify health department.
- ⁵If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.
- ⁶Chronic: more than one month's duration.
- ⁷Recurrent: 2 or more episodes within a 1-year period.
- ⁸Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code _____

FUI Assigned: _____

Complete Incomplete OOS

RVCT Number: _____

**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 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 HIV/AIDS Prevention & Education Services, Washington State Department of Health, at (360) 236-3422, or your local health department.

Comments:

Patient Name¹ (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #: () - - Social Security #: - -

Current Street Address:

City: Zip Code: [1] Alive [2] Dead

Birthdate (mm/dd/yyyy) / / Death Date (mm/dd/yyyy) / / State of Death:

Sex at birth: [1] Male [2] Female Gender or identity change: [1] Male to Female [2] Female to Male Ethnicity: [1] Hispanic [2] Not Hispanic

Race (check all that apply): White Black Asian Native Hawaiian or Pacific Islander American Indian/Alaska Native Marital Status: Married Divorced Widowed Never married Unknown

Country of birth: U.S. Other: _____ If other, length of residence in US: _____

Was patient dx in another state? [1] Yes [2] No If yes, specify state: _____

Residence at time of diagnosis if different than current address: City: County: Zip Code:

Med. Record #/Patient Code:

Name & City of facility of diagnosis:

[1] Outpatient dx² [2] Inpatient dx²

PROVIDER INFORMATION

Physician: Phone: City:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977³

Check all that apply	Yes	No	Unk
Sex with male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factors for hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion, Transplant, or Insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heterosexual relations with:			
Injection drug user.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual man.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV transfusion or transplant....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV risk not specified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worked in health-care or laboratory setting..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, occupation: _____			

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

LABORATORY DATA⁴

Test Date (mm/dd/yyyy) _____

Last documented negative test ___/___/___ Type of test: _____

EARLIEST POSITIVE HIV ANTIBODY TESTS:

Type of Test: Test Date (mm/dd/yyyy) _____

HIV-1 EIA ___/___/___ Test not done

HIV-1 Western Blot or IFA ___/___/___ Test not done

HIV VIRAL LOAD TESTS:

Type of Test: Test Date (mm/dd/yyyy) _____

Earliest HIV Viral Load ___/___/___ Copies per mL _____ Undetectable

Most recent HIV Viral Load ___/___/___ Copies per mL _____ Undetectable

OTHER HIV TESTS

Type of test: Rapid, Antigen, Culture, HIV-2, _____

Date (mm/dd/yyyy): ___/___/___ Result: _____

PHYSICIAN DIAGNOSIS OF INFECTION:

No laboratory tests are available but Physician documents HIV infection Date (mm/dd/yyyy): ___/___/___

EARLIEST DRUG RESISTANCE TEST

Date (mm/dd/yyyy): ___/___/___ Test not done

Type: Genotype Phenotype

Laboratory: _____

CD4 LEVELS

Type of Test:	Test Date (mm/dd/yyyy)	Count	Percent
Earliest CD4	___/___/___	_____ cells/μl	_____ %
Most Recent CD4	___/___/___	_____ cells/μl	_____ %
First CD4 <200 μl or < 14%	___/___/___	_____ cells/μl	_____ %

TREATMENT / SERVICES REFERRALS

	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
This patient is receiving/has been referred for:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV related medical service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV Social Service Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This patient received/ is receiving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Antiretroviral (ARV) therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, earliest date started ARV after diagnosis (mm/dd/yyyy): ___/___/___				
• PCP prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FOR WOMEN				
Is this patient currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Expected delivery date (mm/dd/yyyy) ___/___/___	Yes	No	Unk	

HEALTH DEPARTMENT USE ONLY

HIV AIDS Steno: _____

Date: ___/___/___ Source: _____

New Case Progression Update, no status change

Note AIDS indicator diseases on reverse

CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES If checked, skip Clinical AIDS section on reverse.

HIV TESTING HISTORY

Complete this section if new diagnosis or new patient OR attach completed questionnaire Not applicable

Date of information collected (mm/dd/yyyy): ___/___/___

Information from: patient interview review of medical record

FIRST SELF-REPORTED POSITIVE HIV TEST

Date (mm/yyyy): ___/___/___ State: _____

Registration type: Confidential Anonymous Unk/Refused

LAST SELF-REPORTED NEGATIVE HIV TEST

Never had negative HIV test Unk (Skip to next section)

Date (mm/yyyy): ___/___/___

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1	+	=
first positive test	# of negative tests during prior 2 years	total # of tests in 2 years

ANTIRETROVIRAL (ARV) USE BEFORE DIAGNOSIS OF HIV

Used ARV in 6 months before diagnosis: Yes No Unk

If yes: Names of medications used: _____ Continue in comments on reverse if necessary

First date of ARV use (mm/dd/yyyy): ___/___/___

Currently using ARV: Yes No Unk

If no: Last date of ARV use (mm/dd/yyyy): ___/___/___

DRUG USE

Methamphetamine use? Yes No Unk

If, yes: Injection Non-injection, specify: _____ Unk

PARTNER NOTIFICATION (PN)

For **previously unreported HIV/AIDS cases**, WAC 246-100-072 indicates that the local health officer or designee is required to contact the health care provider within 7 days to offer partner notification assistance.

Health care provider has been contacted to offer PN assistance. Yes No

If no, reason not contacted: _____

Disposition:

Health care provider accepts assistance from LHJ in conducting PN.

Health care provider assumes responsibility for working with patient to conduct PN activities.

1, 2, 3, 4 Footnotes on reverse