

**CLINICAL AIDS**

Disease	Diagnosis Date (mm/dd/yyyy)	dx method <sup>5</sup>	
		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 <sup>6</sup> 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 <sup>6</sup> ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___		<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___		<input type="checkbox"/>
Isosporiasis, chronic <sup>6</sup> 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 <sup>7</sup>	___/___/___	<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 <sup>8</sup>	___/___/___		<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**

- <sup>1</sup>Patient identifier information is not sent to CDC.
- <sup>2</sup>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.
- <sup>3</sup>After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
- <sup>4</sup>If case progresses to AIDS, please notify health department.
- <sup>5</sup>If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.
- <sup>6</sup>Chronic: more than one month's duration.
- <sup>7</sup>Recurrent: 2 or more episodes within a 1-year period.
- <sup>8</sup>Wasting 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:

Date LHJ received the report indicative of a new HIV infection:

Month / Day / Year

/   /

Patient Name<sup>1</sup> (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 dx<sup>2</sup> [2] Inpatient dx<sup>2</sup>

**PROVIDER INFORMATION**

Physician: Phone: City:

Person reporting if other than physician: Phone:

**PATIENT HISTORY SINCE 1977<sup>3</sup>**

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 DATA<sup>4</sup>**

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"/>	<input type="checkbox"/>
This patient is receiving/has been referred for:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• HIV related medical service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• HIV Social Service Case Management	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
• Antiretroviral (ARV) therapy	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

**FOR WOMEN**

Is this patient currently pregnant?  Yes  No  Unk

Expected delivery date (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

**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):

$$\frac{1}{\text{first positive test}} + \frac{\text{\# of negative tests during prior 2 years}}{\text{total \# of tests in 2 years}} =$$

**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.