

XI. Patient Information

Patient Name: (Last, First, M.I.)	State Number:
Date of Birth: ____/____/____ (mm) (dd) (yyyy)	SS#: ____
** Patient Identifier information is not transmitted to CDC **	
Document Source: <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> Other (please specify) _____ (Only <u>ONE</u> source may be used)	
Document Source Date: ____/____/____ (mm) (dd) (yyyy)	

**ADDENDUM FOR ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥ 13 years of age at time of diagnosis)**

Date Form Completed:

____/____/____
(mm) (dd) (yyyy)

XII. PREVIOUS POSITIVE TESTING HISTORY

*****Complete ONLY when there is evidence regarding a positive test before the one which initiated the case report*****

First Positive HIV Test

Has the patient **ever had a previous positive** HIV test? Yes No Unknown Refused

If **YES**, date of First Positive HIV test
____/____/____
(mm) (dd) (yyyy)

If **YES**, in what **STATE** was the **First Positive** HIV test was performed? _____

XIII. PREVIOUS NEGATIVE TESTING HISTORY

Last Negative HIV Test

Has the patient **ever had a negative** HIV test? Yes No Unknown Refused

If **YES**, date of Last Negative HIV test
____/____/____
(mm) (dd) (yyyy)

Number of **negative** HIV tests within 24 mms before first positive # _____ Unknown Refused

If **YES**, in what **STATE** was the **Last Negative** HIV test was performed? _____

XIV. ANTIRETROVIRAL (ARV) or HIV MEDICATIONS

Has the patient **ever taken any** ARV/HIV medications? Yes No Unknown Refused

First date of ARV/HIV medication ____/____/____
(mm) (dd) (yyyy)

Last date of ARV/HIV medication ____/____/____ Patient is currently taking any ARV
(mm) (dd) (yyyy)

Code of ARV medication(s) _____
(See reverse side for codes)

Directions for Completing Form

General Guidance on Responses

Yes	evidence that the event occurred
No	evidence that the event did NOT occur
Unknown	1) evidence that patient said, "Don't know" 2) provider documented "Unknown" or 3) insufficient evidence
Refused	Patient refused, provider documented "Refused," or the facility did not allow for medical record review
Blank	Patient or provider was not asked or source was not investigated

For all dates, only enter information that you have evidence of. For example, if only mm & yyyy are known enter 05/__/2000 or if only the yyyy is known enter __/__/2000.

XI. Patient Information

Indicate patient's last name, first name and middle initial, date of birth and social security number (SS#). Include patient's state number, if known.

Please select the source of Testing and Treatment History (TTH) information by checking the appropriate Document Source box. If you use a source not listed, please note that source on the "Other" line provided. **Only one document source may be used per form.** Record the Document Source Date as follows:

- For Medical Record Review: Date when most recent TTH data provided. Do NOT use the date of review unless no other date is available.
- For Provider Report: Date when TTH information was obtained from patient. If date is unknown, enter date when report was received at health department.
- For Other: Use the date the TTH information was originally collected.

Record the date this form was completed.

XII. Previous Positive Testing History

All of the questions in this section reference the patient's first positive HIV test ever. **Only complete this section when there is evidence regarding a positive test before the one which initiated the case report.** List the mm, dd, and yyyy of the patient's first positive test. If date is unknown, leave date field blank. Indicate the state where the first positive HIV test was performed.

XIII. Previous Negative Testing History

Indicate whether the patient has ever had a negative HIV test prior to receiving their first positive result. List the mm, dd and yyyy of the patient's last negative test. If date is unknown, leave date field blank. Indicate the total number of negative tests the patient had during the twenty-four mms prior to receiving their first positive result. Indicate the state where the last negative HIV test was performed.

XIV. Antiretroviral Medications

Indicate whether the patient has ever taken any HIV or antiretroviral medications (ARVs). If yes, indicate date the patient first began taking HIV or ARV medications. List the date the patient stopped taking ARV medications. List the names of the medications taken using the abbreviation list below. Check the box if the client is currently taking HIV or ARV meds.

Medicine Codes

22= Agenerase (amprenavir)	23= Hydroxyurea	21= Sustiva (efavirenz)
30= Aptivus (tipranavir, TPV)	18= Invirase (saquinavir mesylate)	13= Trizivir (abacavir sulfate/ lamivudine/ zidovudine)
32= Atripla (efavirenz/ emtricitabine/ tenofovir DF)	34= Intelence (etravirine)	27= Truvada (FTC/TDF)
24= Combivir (lamivudine/ zidovudine)	36= Isentress (raltegravir)	01= Videx (didanosine, ddl)
06= Crixivan (indinavir sulfate)	16= Kaletra (lopinavir/ ritonavir)	14= Videx EC (didanosine, l)
11= Emtriva (emtricitabine, FTC)	31= Lexiva (fosamprenavir, 908)	17= Viracept (nelfinavir mesylate)
03= Epivir (lamivudine, 3TC)	07= Norvir (ritonavir)	05= Viramune (nevirapine)
28= Epzicom (3TC/ABC)	33= Prezista (darunavir, DRV)	12= Viread (tenofovir)
25= Fortovase (saquinavir)	09= Rescriptor (delavirdine mesylate)	04= Zerit (stavudine, d4T)
10= Fuzeon (enfuvirtide, T-20)	26= Retrovir (zidovudine, ZDV, AZT)	20= Ziagen (abacavir sulfate)
19= Hepsera (adefovir)	15= Reyataz (atazanavir sulfate)	88= Other
02= Hivid (zalcitabine, ddC)	08= Saquinavir (Fortavase, Invirase)	99= Unspecified
	35= Selzentry (maraviroc)	