



Florida Adult HIV/AIDS Confidential Case Report

(Patients ≥ 13 years of age at time of diagnosis)

I. HEALTH DEPT USE ONLY

Date rec'd at Health Dept. (mm/dd/yyyy format)

Document Source	New Investigation yes no	Report Medium FV M F Ph ET DK	Surveillance Method A F P R	State Number
A				
Report Status New Update	Rptg. CHD City		Date form completed: / /	

II. PATIENT IDENTIFIER INFORMATION-data not transmitted to CDC

Patient Name (Last, First, MI)	SS#: - -
Address	City County
State Zip	Phone () City/County Patient Number

III. DEMOGRAPHIC INFORMATION-complete ALL fields

Diagnostic Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> UNK <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Other _____	Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Death: Date: / / State/Terr of Death: _____
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Ethnicity (select one): Hispanic Not Hispanic or Latino Unknown

Race: (select all that apply) Black/AA Asian Native American or Alaskan White Hawaiian/PI Unk

Residence at Diagnosis: Same as Current Street Address: _____
City: _____ County: _____ State/Country: _____ Zip: _____

IV. FACILITY OF DIAGNOSIS

V. PATIENT HISTORY- complete ALL fields

Facility Name:	<p>Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (Respond to ALL Categories)</p> <table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Unk</th> </tr> </thead> <tbody> <tr> <td>Sex with male.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sex with female.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Injected non-prescription drugs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Received clotting factor for hemophilia/coagulation disorder.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Specify disorder: <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other (specify): _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>HETEROSEXUAL relations with any of the following:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Intravenous/Injection Drug User.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Bisexual male (applies to females only).....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Person with hemophilia/coagulation disorder.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Transfusion recipient with documented HIV infection.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Transplant recipient with documented HIV infection.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Person with AIDS or documented HIV infection, risk unspecified.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Received transfusion of blood/blood components (other than clotting factor) First Date: / / Last Date: / /</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Received organ transplant, tissue or artificial insemination.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Worked in healthcare or clinical laboratory..... 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Facility Type (check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other																																																																					
Facility Code:																																																																					
Facility Setting (check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Other																																																																					
Provider Name (Last, First, MI)																																																																					
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Person Completing Form (Last, First, MI)																																																																					
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VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test - mm/dd/yyyy)			HIV Detection Tests: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 NAT		
HIV-1/2 EIA			HIV-1 Qual PCR RNA		
HIV-1 Western Blot/IFA			HIV-1 P24 Antigen		
Other			HIV-1 Qual PCR DNA		
HIV-2 EIA			Other		
Viral Load Test: (<u>most recent</u> test- mm/dd/yyyy)			Immunologic Lab Test: (test date-mm/dd/yyyy)		
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status		Collection Date
HIV-1 NASBA			CD4 Count: _____ cells/ul (_____ %)		
HIV-1 RT-PCR			First<200 or <14% of total lymphocytes		
HIV-1 bDNA			CD4 Count: _____ cells/ul (_____ %)		
Other					

Physician Diagnosis:
If HIV laboratory test were not documented, is HIV diagnosis documented by a physician? Yes No Unk

If yes, enter date of diagnosis (mm/dd/yyyy) _____

