COUNTY OF LOS ANGELES CONFIDENTIAL PROVIDER HIV/AIDS ADULT CASE REPORT

Patients ≥13 Years of Age at Time of Diagnosis

Please return completed form to:

COUNTY OF LOS ANGELES, DEPARTMENT OF PUBLIC HEALTH
600 S. COMMONWEALTH AVE 10TH FLOOR - SUITE 1260 LOS ANGELES, CA 90005

For questions or to report via phone: (213) 351-8516

HEALTH DEPARTMENT USE ONLY

Doc. source: _____ Stateno:_____
Report Medium:_____ Cityno:_____
Surveillance method:_____

1. PROVIDER/FACILITY INFORMATION

Person completing form: Phone: Date completed:

Physician: Physician Phone:

Facility Name: Phone:

Facility Address/City/State/Zip:

Facility Type:
Inpatient: ☐ Hospital ☐ Other:_____
Outpatient: ☐ Private Physician ☐ Adult HIV Clinic ☐ Other:_____
Screening, Diagnostic, Referral Agency: ☐ STD Clinic ☐ Other:_____
Other Facility: ☐ ER ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other:_____

2. PATIENT INFORMATION

Patient Last Name: First Name: Middle Name:

AKA (Chosen Name, Preferred Name, Nickname, Previous Last Name, etc.)

Address Type: ☐ Residential ☐ Correctional Facility ☐ Homeless ☐ Postal ☐ Foster Home ☐ Shelter ☐ Temporary ☐ Military ☐ Other

Current Street Address:

City:	Zip Code:	State:	Phone #:
Date of Birth:	Social Security #:		Medical Record #:

Vital Status: ☐ Alive ☐ Dead	Date of Death:	State of Death:	Status[1]: ☐ HIV ☐ AIDS

Country of Birth: ☐ U.S. ☐ Other/ U.S. Dependency (*specify*):_____

Sex assigned at Birth:
☐ Male
☐ Female
☐ Unknown

Current gender identity:
☐ Male ☐ Transgender Man (Female-to-Male)
☐ Female ☐ Transgender Woman (Male-to- Female)
☐ Non-Binary / Gender Nonconforming ☐ Unknown
☐ Additional gender identity (specify):_____

Race (check all that apply): ☐ White ☐ Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Chinese ☐ Vietnamese ☐ Japanese ☐ Asian Indian ☐ Filipino ☐ Laotian ☐ Korean ☐ Cambodian
☐ Pacific Islander
☐ Hawaiian ☐ Guamanian ☐ Samoan
☐ Other (*specify*):_____

Ethnicity:
☐ Hispanic/Latinx
☐ Not Hispanic/Non-Latinx
☐ Unknown

Expanded Race/Ethnicity:

3. RESIDENCE/FACILITY AT HIV/AIDS DIAGNOSIS

☐ Check if patient address/facility at HIV diagnosis are same as current (if checked, leave the rest of this section blank)

Address at **time of diagnosis** if different than current address:

Facility of HIV Diagnosis: Phone:

Facility Address/City/State/Zip:

Facility Type:
Inpatient: ☐ Hospital ☐ Other:_____
Outpatient: ☐ Private Phys. ☐ HIV Clinic ☐ Other: _____
Screening, etc: ☐ STD Clinic ☐ Other: _____
Other: ☐ ER ☐ Lab ☐ Corrections ☐ Unknown

4. PATIENT HISTORY and RISK FACTORS[2]

Check all that apply:

	Yes	No	Unk
Sex with male	☐	☐	☐
Sex with female	☐	☐	☐
Injection drug use	☐	☐	☐
Perinatal infection with HIV	☐	☐	☐
Heterosexual relations with:			
Injection drug user	☐	☐	☐
Bisexual male	☐	☐	☐
Person with documented HIV/AIDS	☐	☐	☐

Other documented risk *(specify)*:

5. CLINICAL: ACUTE HIV INFECTION AND OPPORTUNISTIC ILLNESSES

Suspect Acute HIV? ☐ Yes ☐ No ☐ Unknown

Clinical signs/symptoms consistent with acute retroviral syndrome? (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy) ☐ Yes → Date of sign/symptom onset: _____ ☐ No ☐ Unknown

OPPORTUNISTIC ILLNESSES[3]

	Diagnosis date		Diagnosis date
☐ Candidiasis, esophageal		☐ Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	
☐ Coccidiodomycosis, disseminated or extrapulmonary		☐ M. tuberculosis, pulmonary	
☐ Cryptococcosis, extrapulmonary		☐ Pneumocystis pneumonia	
☐ Cytomegalovirus disease (other than in liver, spleen, nodes)		☐ Toxoplasmosis of brain, onset at >1 mo. age	
☐ Herpes simplex: chronic ulcer(s) (>1 mo duration) bronchitis, pneumonitis or esophagitis		☐ Wasting syndrome due to HIV	
☐ Kaposi's sarcoma		☐ Other:_____	

6. PREGNANCY

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

7. TREATMENT SERVICES/REFERRALS

Has this patient been informed of their HIV infection? ☐ Yes ☐ No ☐ Unknown

Is there evidence of linkage to HIV medical care?

☐ Yes; provide date of **first visit for HIV care** documented by provider:_____ ☐ No ☐ Unknown

[1,2,3]Footnotes on reverse

To download this form, go to http://www.publichealth.lacounty.gov/DHSP/reportcase.htm

Revised 08/25/2020

PLEASE DO NOT SEND THE REPORT BY E-MAIL OR FAX

Please turn over and complete reverse side of form

8. HIV DIAGNOSTIC TESTS

REQUIRED: Attach copies of all relevant laboratory results for HIV diagnosis and indicate that labs are attached:

☐ **LABS ARE ATTACHED** (IF CHECKED, THE GREY BOXES IN THIS SECTION CAN BE LEFT BLANK)

OPTIONAL: Document HIV Immunoassays (Non-differentiating/Type-Differentiating) lab results below.

HIV Immunoassays (Non-differentiating)

	DATE COLLECTED (MM/DD/YYYY)	Rapid Test	RESULT (Check one per row)		
			Positive/ Reactive	Negative/ Non-Reactive	Indeterminate (IND)
HIV-1/2 Ag/Ab		☐	☐	☐	☐
HIV-1 RNA/DNA NAAT (Qual)			☐	☐	☐
Other:_____		☐	☐	☐	☐

HIV Immunoassays (Type-differentiating)

	DATE COLLECTED (MM/DD/YYYY)	Rapid Test	RESULTS (Check one for each column)		
			Overall Interpretation	HIV-1 Ag	HIV-1 Ab
HIV-1/2 Ag/Ab and Type Differentiating *(e.g. Bio-Rad BioPlex 5th Generation)*		☐	☐Reactive ☐Non-Reactive	☐Reactive ☐Non-Reactive	☐Reactive ☐Non-Reactive ☐Reactive, Undifferentiated
HIV-1/2 Type-Differentiating *(differentiates between HIV1 Ab & HIV2 Ab)* Role of test in diagnostic algorithm: ☐ Screening/Initial ☐ Confirmatory/Supplemental		☐	Overall Interpretation: ☐HIV-1 Positive ☐HIV-1 IND ☐HIV IND ☐HIV Negative ☐HIV-2 Positive ☐HIV-2 IND ☐HIV Positive, Untypable ☐HIV-2 Positive with HIV-1 Cross-Reactivity		

DOCUMENTATION OF TESTS

Date of last documented negative HIV test (before HIV diagnosis date): _____
Specify type of test: _____

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinician? ☐ Yes ☐ No ☐ Unknown
If Yes → Date of documentation by care provider:_____

9. HIV CARE TESTS

	DATE COLLECTED (MM/DD/YYYY)	RESULTS *For HIV Viral Load, circle one interpretation: <, =, or >*
Earliest HIV Viral Load		< = > _____ **copies/mL** _____ **Log**
Most Recent HIV Viral Load		< = > _____ **copies/mL** _____ **Log**
HIV-1 Genotypic Tests		
Earliest CD4		**Count:** _____ cells/μL **Percentage**: _____%
Most recent CD4		**Count:** _____ cells/μL **Percentage:** _____%
First CD4 <200 μL		**Count:** _____ cells/μL **Percentage**: _____%

REPORTING REQUIREMENTS AND FOR PARTNER NOTIFICATION

- In accordance with Health and Safety Code (HSC) 121022(a), CCR Title 17, Section 2643.5 and 2643.10, health care providers must report Human Immunodeficiency Virus (HIV) infection at any stage, including HIV infection, progression to stage 3 (AIDS) within seven (7) calendar days. In addition, acute HIV infection must be reported within one (1) working day to the local health officer of the jurisdiction in which the patient resides by telephone (213-351-8516). 17 CCR 2500(h) and (k). The reporting does not require patient consent. HIPAA, 45 CFR 164.512(b)(1)(i).
- California state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection and establishes rules for providing such assistance (HSC 120175, 121015, 121025).
- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call (213-639-4277).

10. HIV TESTING AND TREATMENT HISTORY

Date of patient encounter during which testing/treatment history was provided: _____
Information from: ☐ Patient interview ☐ Review of medical record ☐ Provider report

PATIENT REPORTED HIV TESTING HISTORY

Ever had a previous positive HIV test?
☐ Yes ☐ No ☐ Unknown

Date of first positive test: _____

Ever had a negative HIV test?
☐ Yes ☐ No ☐ Unknown

Date of last negative test:_____

Number of negative HIV tests in 24 months before first positive test: _____ ☐ Unknown

HISTORY OF HIV-RELATED MEDICATIONS

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

If Yes, reason for ARV use (select all that apply):		**Date began**	**Date of last use**
☐ For HIV treatment?	ARV med:_____	_____	_____
☐ For PrEP?	ARV med:_____	_____	_____
☐ For PEP?	ARV med:_____	_____	_____
☐ For Pregnancy?	ARV med:_____	_____	_____
☐ Hep B treatment?	ARV med:_____	_____	_____
☐ Other_____	ARV med: _____	_____	_____

11. SUBSTANCE USE

Has patient used any illicit drugs in the past year? ☐ Yes ☐ No ☐ Unknown

If Yes, Check all that apply below

☐ Cocaine ☐ Hallucinogens ☐ Inhalants ☐ Other: _____
☐ Heroin ☐ Methamphetamine ☐ Misuse of Prescription Opioids

12. PARTNER INFORMATION

Name of partner(s):	**Partner contact information:**	**Relationship to partner:**
		☐ Main sex partner ☐ Casual sex partner ☐ Transactional sex partner ☐ Needle-sharing partner ☐ Unknown/Other
		☐ Main sex partner ☐ Casual sex partner ☐ Transactional sex partner ☐ Needle-sharing partner ☐ Unknown/Other

Comments:

HEALTH DEPARTMENT USE ONLY

Assignee:_____ Reviewed by:_____ Entered by:_____ Entry date: _____

Footnotes:

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

[2] Patient history after 1977 and before the first positive HIV antibody test or AIDS diagnosis for this patient.

[3] Refer to attached 'Guidance for Completing Adult Case Report Form' for the complete list of opportunistic illnesses indicative of Stage 3 (AIDS) infection.

County of Los Angeles Public Health