WASHINGTON STATE CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

STATE HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno:_____

Date: ____/____/_____ Source: _____

☐ New case ☐ Progression ☐ Update, no status change

PATIENT INFORMATION

Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

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

Email:

Current Street Address: Date Address Verified: ____/____/____

City: Zip Code: ☐ Alive ☐ Dead

Birthdate (mm/dd/yyyy) ____/____/____ Death date (mm/dd/yyyy) ____/____/____ State of death:

Sex at birth: ☐ Male ☐ Female

Current gender identity: ☐ Woman ☐ Trans Woman ☐ Man ☐ Trans Man ☐ Non-Binary ☐ Genderqueer ☐ Other_____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Other_____ (Refer to Supplemental List on p.3)

Marital Status: ☐ Married ☐ Never married ☐ Separated ☐ Unknown ☐ Divorced ☐ Widowed

Race (check all that apply): ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Other(s)_____ (Refer to Supplemental List on p.3)

Country of birth: ☐ U.S. ☐ Other: _____

If other, date of entry into U.S.: ____/____/____

Primary Language: ☐ English ☐ Other: _____ (Refer to Supplemental List on p.3)

Was the patient dx in another state or country? ☐ Yes ☐ No

If yes, specify state or country: _____

Residence at time of **HIV** diagnosis if different than current address:

Residence at time of **AIDS** diagnosis (if applicable) if different than current address:

Medical Record # Patient Code:

FACILITY AND PROVIDER INFORMATION

Name and City of facility of **HIV** diagnosis:

_____

☐ Outpatient diagnosis[2] ☐ Inpatient diagnosis ☐ ER diagnosis

Name and City of facility of **AIDS** diagnosis (if applicable):

_____

☐ Outpatient diagnosis[2] ☐ Inpatient diagnosis ☐ ER diagnosis

Provider of **HIV** Diagnosis:

Provider of **AIDS** Diagnosis (if applicable):

Person reporting: Phone:

Facility reporting if other than facility of diagnosis:

HIV DIAGNOSTIC TESTS

Type of Test *At least 2 antibody tests must be indicated for an HIV diagnosis* IA = Immunoassay	**Collection date**	Rapid test	**Result** (check one per row) Positive/ Reactive	Indeterminate	Negative/ Non-Reactive
Last Negative Test (prior to HIV diagnosis)	__/__/__				
HIV-1/2 Ag/Ab IA (4th Gen)	__/__/__				
HIV-1/2 EIA IA (2nd or 3rd Gen)	__/__/__				
HIV 1 and 2 Type Differentiating IA (Supplemental Ab Test)	__/__/__		☐ HIV-1 ☐ HIV-2 ☐ Undiff	☐ HIV-1 ☐ HIV-2	☐ HIV-1 ☐ HIV-2
HIV-1 Western Blot	__/__/__				
HIV-1 RNA/DNA Qualitative NAAT	__/__/__				
OTHER: _____	__/__/__				

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider?

☐ Yes → Date of documentation by care provider: ____/____/____

☐ No

☐ Unknown

HIV CARE TESTS[4]

HIV VIRAL LOAD TESTS

	Test Date	Copies/ml
Earliest HIV viral load	____/____/____	_____
Most recent HIV viral load	____/____/____	_____

EARLIEST DRUG RESISTANCE TEST

Date: ____/____/____ ☐ Genotype ☐ Phenotype

Laboratory:_____

CD4 LEVELS

	Test Date	Count	%
Earliest CD4	____/____/____	_____cells/µl	_____%
Most recent CD4	____/____/____	_____cells/µl	_____%
First CD4 <200 µl	____/____/____	_____cells/µl	_____%

PATIENT HISTORY SINCE 1977[3]

Check all that apply:	Yes	No	Unk		Yes	No	Unk
Sex with male……	☐	☐	☐	**Heterosexual relations with:**			
Sex with female……	☐	☐	☐	Person who injects drugs…	☐	☐	☐
Person who injects drugs……	☐	☐	☐	Bisexual man……	☐	☐	☐
Received clotting factors for hemophilia……	☐	☐	☐	Person with hemophilia……	☐	☐	☐
Transfusion, Transplant, or Insemination……	☐	☐	☐	Person living w/ HIV……	☐	☐	☐
Perinatal Transmission…… (Biological mother known HIV+)	☐	☐	☐	Other Risk(s): _____			

Please turn over and complete reverse side

OPPORTUNISTIC ILLNESSES[4,5]

	Diagnosis date		Diagnosis date
☐ Candidiasis, esophageal	___/___/___	☐ Kaposi's sarcoma	___/___/___
☐ Cryptococcosis, extrapulmonary	___/___/___	☐ PCP/PJP (Pneumocystis pneumonia)	___/___/___
☐ Cytomegalovirus disease (other than in liver, spleen, nodes)	___/___/___	☐ Wasting syndrome due to HIV	___/___/___
☐ Herpes simplex: chronic ulcer(s) (>1 mo. duration) bronchitis, pneumonitis or esophagitis	___/___/___	☐ Other(s): _____	___/___/___

HIV TESTING AND TREATMENT HISTORY

Date patient reported info: ___/___/___ Information from: ☐ Patient interview ☐ Review of medical record ☐ Provider report ☐ PEMS ☐ Other

FIRST POSITIVE HIV TEST

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

Date of first positive test: ____ /____ / ____

NEGATIVE HIV TESTS

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:_____

HISTORY OF HIV-RELATED MEDICATIONS (check all that apply)

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

Reason	Name(s) of medication(s)	Date began	Currently Taking?	Date of last use (if no longer taking):
☐ HIV Treatment.....	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
	☐ _____	___/___/___	☐ Yes	___/___/___
☐ PREP.....	☐ _____	___/___/___	☐ Yes	___/___/___
☐ PEP	☐ _____	___/___/___	☐ Yes	___/___/___
☐ PCP Prophylaxis..	☐ Bactrim ☐ Other_____	___/___/___	☐ Yes	___/___/___
☐ Other ARV.....	☐ _____	___/___/___	☐ Yes	___/___/___

DRUG USE

Methamphetamine use? ☐ No ☐ Unknown

☐ Yes → ☐ Injection ☐ Non-injection, specify: _____ ☐ Unk

TREATMENT/SERVICES REFERRALS

	Yes	No	Unk	N/A
Has this patient been informed of his/her HIV status?.....	☐	☐	☐	
This patient is receiving/has been referred for:				
▪ HIV related medical service.....	☐	☐	☐	
▪ HIV Social Service Case Management.....	☐	☐	☐	
▪ Substance abuse treatment services.....	☐	☐	☐	☐

FOR WOMEN

Is patient currently pregnant?

☐ No

☐ Unknown

☐ Yes→ Expected delivery date:

____/____/_____

Please return completed form to:

Yakima Health District

1210 Ahtanum Ridge Drive

Yakima, WA 98903

(509) 249-6541

Scan code to access footnotes, reporting requirements, and lists found on page 3.

COMMENTS

FOR STATE HEALTH DEPARTMENT USE ONLY

eHARS FORM INFO

STATENO: Date received:

Document Source: ☐ Inpatient ☐ Outpatient ☐ ER ☐ Other:_____

Did this document initiate a new investigation?: ☐ Yes ☐ No

Report Medium: ☐ Paper, field ☐ Paper, fax ☐ Paper, mail ☐ Phone ☐ Electronic

Surveillance Method: ☐ Active ☐ Passive ☐ Follow-Up

Date form completed: _____

Case report completed by:
Phone:

Facility completing form:

LOCAL FIELDS

Transgender? ☐ FM ☐ MF ☐ Other:
Additional Gender Identity:

LHJ Notification Date:
LHJ Notification County:

SOUNDEX

Last Name Soundex(s): _____
☐ CDC Soundex check complete ☐ No Soundex matches
Soundex Matches/Duplicate Review:

Comments:

FOOTNOTES

1 Patient identifier information is not sent to CDC.

2 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.

3 After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.

4 If case progresses to AIDS, please notify health department.

5 Opportunistic illnesses include: Candidiasis, bronchi, trachea, or lungs; Candidiasis, esophageal; Cervical cancer, invasive; Coccidioidomycosis, disseminated or extrapulmonary; Cryptococcosis, extrapulmonary; Cryptosporidiosis, chronic intestinal; Cytomegalovirus disease (other than liver, spleen, or nodes); Cytomegalovirus retinitis (with loss of vision); HIV encephalopathy; Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis; Histoplasmosis, diss. or extrapulmonary; Isosporiasis, chronic intestinal; Kaposi's sarcoma; Lymphoma, Burkitt's (or equivalent); Lymphoma, immunoblastic (or equivalent); Lymphoma, primary in brain; Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary; M. tuberculosis, pulmonary; M. tuberculosis, diss. or extrapulmonary; Mycobacterium of other or unidentified species, diss. or extrapulmonary; Pneumocystis pneumonia; Pneumonia, recurrent; Progressive multifocal leukoencephalopathy; Salmonella septicemia, recurrent; Toxoplasmosis of brain; Wasting syndrome due to HIV

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 a 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 Infectious Disease Prevention Section Field Services, DOH, at (360) 236-3482 or (360) 236-3484, or your local health department. In King County, please call Public Health Seattle & King County, at (206)263-2410.

For questions please contact:

Washington State Department of Health
Office of Infectious Disease
Assessment Unit
(360) 236-3464

Washington State Department of Health

DOH 150-002 October 2022

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

ETHNICITY

A) Hispanic, Latino/a, Latinx
B) Non-Hispanic, Latino/a, Latinx
C) Patient declined to respond
D) Unknown

PREFERRED LANGUAGE

A) Amharic
B) Arabic
C) Balochi/Baluchi
D) Burmese
E) Cantonese
F) Chinese
G) Chamorro
H) Chuukese
I) Dari
J) English
K) Farsi/ Persian
L) Fijian
M) Filipinio/Pilipino
N) French
O) German
P) Hindi
Q) Hmong
R) Japanese
S) Karen
T) Khmer/Cambodian
U) Kinyarwanda
V) Korean
W) Kosraean
X) Lao
Y) Mandarin
Z) Marshallese
AA) Mizteco
BB) Nepali
CC) Oromo
DD) Panjabi/Punjabi
EE) Pashto
FF) Portuguese
GG) Romanian/Rumanian
HH) Russian
II) Samoan
JJ) Sign Language
KK) Somali
LL) Spanish/Castilian
MM) Swahili/Kiswahili
NN) Tagalog
OO) Tamil
PP) Telugu
QQ) Thai
RR) Tigrinya
SS) Ukrainian
TT) Urdu
UU) Vietnamese
VV) Other languages
WW) Patient declined to respond
XX) Unknown

RACE

A) Afghan
B) Afro-Caribbean
C) Alaska Native
D) American Indian
E) Arab
F) Asian
G) Asian Indian
H) Bamar/Burman.Burmese
I) Bangladeshi
J) Bhutanese
K) Black or African American
L) Central American
M) Cham
N) Chicano/a or Chicanx
O) Chinese
P) Congolese
Q) Cuban
R) Dominican
S) Egyptian
T) Eritrean
U) Ethiopian
V) Fijian
W) Filipino
X) First Nations
Y) Guamanian or Chamorro
Z) Hmong/Mong
AA) Indigenous– Latino/a. Latinx
BB) Indonesian
CC) Iranian
DD) Iraqi
EE) Japanese
FF) Jordian
GG) Karen
HH) Kenyan
II) Khmer/Cambodian
JJ) Korean
KK) Kuwaiti
LL) Lao
MM) Lebanese
NN) Malaysian
OO) Marshallese
PP) Mestizo
QQ) Mexican/Mexican American
RR) Middle Eastern
SS) Mien
TT) Morrocan
UU) Native Hawaiian
VV) Nepalese
WW) North African
XX) Oromo
YY) Pacific Islander
ZZ) Pakistani
AAA) Puerto Rican
BBB) Romanian/ Rumanian
CCC) Russian
DDD) Samoan
EEE) Saudi Arabian
FFF) Somali
GGG) South African
HHH) South American
III) Syrian
JJJ) Taiwanese
KKK) Thai
LLL) Tongan
MMM) Ugandan
NNN) Ukranian
OOO) Vietnamese
PPP) White
QQQ) Yemeni
RRR) Other Race
SSS) Patient declined to answer
TTT) Unkown