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| **DEPARTMENT OF HEALTH SERVICES (DHS)**Division of Public HealthF-44338 (12/2019) | **STATE OF WISCONSIN**Wis. Stat. § 252.05 requires that this information be reported. |
| **WISCONSIN HIV INFECTION AND AIDS CASE REPORT** |
| (Patients >13 Years of Age at Time of Diagnosis) |
| **PATIENT IDENTIFICATION** |
| Patient’s Legal Name | First Name | Middle Name  | Last Name  |
|  |       |       |       |
| Also Known As (e.g., alias, married, maiden) | First Name | Middle Name  | Last Name  |
|  |       |       |       |
| Address Type[ ]  Residential[ ]  Correctional Facility | [ ]  Military Base[ ]  Foster Home[ ]  Homeless | [ ]  Postal[ ]  Shelter [ ]  Temporary | [ ]  Other |
| Current Street Address | If current address is a facility (e.g., corrections, nursing home, shelter), provide name |
|       |       |
| City | County | State / Country | Zip Code |
|       |       |       |       |
| Telephone – Primary | Telephone - Secondary | Medical Record Number | Social Security Number (see page 4) |
|     -       |     -       |       |       |
| **PATIENT DEMOGRAPHICS (Record all dates as mm/dd/yyyy)** |
| Date of Birth | Alias Date of Birth | Country of Birth |
|       |       | [ ]  US [ ]  Other / US Dependency - specify:        |
| Sex Assigned at Birth | Current Gender Identity |
| [ ]  Male [ ]  Female | [ ]  Male | [ ]  Transgender Male-to-Female (MTF) | [ ]  Unknown |
| [ ]  Unknown | [ ]  Female | [ ]  Transgender Female-to-Male (FTM | [ ]  Additional Gender Identity - specify:       |
| **Ethnicity** | [ ]  Hispanic/Latino[ ]  Not Hispanic/Latino[ ]  Unknown | **Race**(check all that apply) | [ ]  American Indian/Alaska Native | [ ]  Asian | [ ]  Black/African AmericaDHS State Number |
|  |  |  | [ ]  Native Hawaiian/Pacific Islander | [ ]  White | [ ]  Unknown |
| Relationship Status | [ ]  Married [ ]  Married and Separated [ ]  Divorced [ ]  Partnered / Significant Other [ ]  Widowed[ ]  Single and Never Married [ ]  Unknown [ ]  Other - specify:        |
| Vital Status: [ ]  Alive [ ]  Dead | Date of Death | State of Residence at Time of Death |
|  |       |       |
| **RESIDENCE AT DIAGNOSIS (add additional addresses in Comments Section)** |
| [ ]  **Check if SAME AS CURRENT ADDRESS and go to the next section** |
| Street Address at Diagnosis | City | County | State / Country | Zip Code |
|       |       |       |       |       |
| **FACILITY PROVIDING INFORMATION (Record all dates as mm/dd/yyyy)** |
| Facility Name |
|       |
| Street Address |
|       |
| City | County | State/Country | Zip Code |
|       |       |       |       |
| **Facility****Type** | **Inpatient**[ ]  Hospital[ ]  Other (specify):       | **Outpatient**[ ]  Private Physician’s Office[ ]  Adult HIV Clinic[ ]  Other - specify:       | **Other Facility**[ ]  CTR [ ]  STD Clinic [ ]  Community Health Center[ ]  Emergency Room [ ]  Blood / Plasma Center [ ]  Corrections [ ]  Other - specify:       |
| Date Form Completed | Person Completing Form | Telephone | If CTR Agency, provide client’s CTR test ID No.:  |
|       |       |     -       |       |
| Provider Name | Telephone | Specialty |
|       |     -       |       |

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| **FACILITY OF DIAGNOSIS**  |
| [ ]  **Check if SAME as Facility Providing Information and go to the Next Section** |
| Facility Name |
|       |
| Street Address |
|  |
| City | City | City | City |
|       |       |       |       |
| FacilityType | **Inpatient**[ ]  Hospital[ ]  Other (specify):       | **Outpatient**[ ]  Private Physician’s Office[ ]  Adult HIV Clinic[ ]  Other - specify:       | **Other Facility** |
| [ ]  CTR | [ ]  Emergency Room | [ ]  Blood / Plasma Center[ ]  Corrections |
| [ ]  STD Clinic | [ ]  Community Health Center | [ ]  Other - specify:       |
| Provider Name | Telephone | Specialty |
|       |     -       |       |
| **PATIENT HISTORY (Respond to ALL Questions) (record all dates as mm/dd/yyyy)**  |
| After 1977 and before the earliest known diagnosis of HIV infection, this patient had: |
| Sex with male | [ ]  Yes [ ]  No [ ]  Unknown |
| Sex with female | [ ]  Yes [ ]  No [ ]  Unknown |
| Injected drugs not prescribed to patient | [ ]  Yes [ ]  No [ ]  Unknown |
| HETEROSEXUAL sexual relations with any of the following: |
| Heterosexual contact with intravenous / injection drug user | [ ]  Yes [ ]  No [ ]  Unknown |
| Heterosexual contact with bisexual male | [ ]  Yes [ ]  No [ ]  Unknown |
| Heterosexual contact with person with hemophilia / coagulation disorder with documented HIV infection | [ ]  Yes [ ]  No [ ]  Unknown |
| Heterosexual contact with transfusion recipient with documented HIV infection | [ ]  Yes [ ]  No [ ]  Unknown |
| Heterosexual contact with transplant recipient with documented HIV infection | [ ]  Yes [ ]  No [ ]  Unknown |
| Heterosexual contact with person with documented HIV infection, risk not specified | [ ]  Yes [ ]  No [ ]  Unknown |
| Other – Answer only if statement describes mode of transmission |
| Received clotting factor for hemophilia / coagulation disorder | [ ]  Yes [ ]  No [ ]  Unknown |
| Specify clotting factor:       | Date received:       |
| Received transfusion of blood / blood components (other than clotting factor) (document reason in Comments Section) | [ ]  Yes [ ]  No [ ]  Unknown |
| First date received:       | Last date received:       |
| Received transplant of tissue / organs or artificial inseminationDate received:       | [ ]  Yes [ ]  No [ ]  Unknown |
| Worked in a healthcare or clinical laboratory setting. If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting in Comments Section | [ ]  Yes [ ]  No [ ]  Unknown |
| Perinatally infected | [ ]  Yes [ ]  No [ ]  Unknown |
| Other documented risk (include detail in Comments Section) | [ ]  Yes [ ]  No [ ]  Unknown |

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| **LABORATORY DATA (record additional tests in Comments Section) (record all dates as mm/dd/yyyy)**  |
| **HIV Antibody Test at Diagnosis (Non-differentiating)** (Earliest Test) |
|  | Pos | Neg | Ind | Collection Date |
| HIV-1 EIA |   |   |   |       |
| HIV-1/2 EIA |   |   |   |       |
| HIV-1/2 Ag/AB |   |   |   |       |
| HIV-1 WB/IFA |   |   |   |       |
| HIV-2 EIA |   |   |   |       |
| HIV-2 WB |   |   |   |       |
| Other HIV AB TestSpecify:       |   |   |   |       |
| **HIV Antibody Test at Diagnosis (Differentiating)** (Earliest Test) |
|  | HIV-1 | HIV-2 | Both | Neg | Collection Date |
| HIV-1/2 Multispot |   |   |   |   |       |
| **HIV Detection/Viral Load Tests (Quantitative)** (Earliest & Most Recent) |
|  | Copies/mI | Collection Date |
| HIV-1 RNA/DNA NAAT (earliest) |       |       |
| HIV-1 RNA/DNA NAAT (most recent) |       |       |
| HIV-2 RNA/DNA NAAT |       |       |
| **HIV Detection Tests (Qualitative)** (Earliest Test) |
|  | Collection Date |
| HIV-1 RNA/DNA NAAT (Nucleic Acid Amplification Test) |
|  [ ]  Detectable [ ]  Undetectable |       |
| HIV-2 RNA/DNA NAAT (Nucleic Acid Amplification Test) |
|  [ ]  Detectable [ ]  Undetectable |       |
| Other Detection Test - Specify:       |       |
| **Immunologic Tests (CD4)** |
| CD4 at or Closest to Current Diagnostic Status: | Collection Date |
| Count |       | Percent |      % |       |
| First CD4 <200 µL or <14%:  |  |  |  |
| Count |       | Percent |      % |       |
| Most Recent CD4:  |  |  |  |
| Count |       | Percent |      % |       |
| **Resistance Tests** |
|  |  | Collection Date |
| Genotyping [ ]  Yes [ ]  No [ ]  Unknown |       |
| Phenotyping [ ]  Yes [ ]  No [ ]  Unknown |       |
| **Past HIV Testing** |
| Has this patient ever had a negative HIV test?  [ ]  Yes [ ]  No [ ]  Unknown |
| If yes, specify test and date: |       |
| If HIV laboratory tests were not documented, is the HIV diagnosis documented by a physician? [ ]  Yes [ ]  No [ ]  Unknown |  |
|  |  |
| If yes, date of physician documentation: |       |
| **CLINICAL Definitive Diagnosis (record all dates as mm/dd/yyyy)**  |
|  | Diagnosis Date |
| Candidiasis, bronchi, trachea, or lungs |       |
| Candidiasis, esophageal |       |
| Carcinoma, invasive cervical |       |
| Coccidioidomycosis, disseminated or extrapulmonary |       |
| Cryptococcosis, extrapulmonary |       |
| Cryptosporidiosis, chronic intestinal (>1 mo. duration) |       |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) |       |
| Cytomegalovirus retinitis (with loss of vision) |       |
| HIV encephalopathy |       |
| Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis |       |
| Histoplasmosis, disseminated or extrapulmonary |       |
| Isosporiasis, chronic intestinal (>1 mo. duration) |       |
| Kaposi’s sarcoma |       |
| Lymphoma, Burkitt’s (or equivalent) |       |
| Lymphoma, immunoblastic (or equivalent) |       |
| Lymphoma, primary in brain |       |
| Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary |       |
| M. tuberculosis, pulmonary |       |
| M. tuberculosis, disseminated or extrapulmonary |       |
| Mycobacterium, of other / unidentified species, disseminated or extrapulmonary |       |
| Pneumocystis pneumonia |       |
| Pneumonia, recurrent, in 12 mo. period |       |
| Progressive multifocal leukoencephalopathy |       |
| Salmonella septicemia, recurrent |       |
| Toxoplasmosis of brain, onset at >1 mo. of age |       |
| Wasting syndrome due to HIV |       |

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| **ANTIRETROVIRAL (ARV) USE HISTORY / SERVICE REFERRALS (record all dates as mm/dd/yyyy)** |
| Has patient ever been prescribed antiretrovirals (ARVs)? [ ]  Yes [ ]  No [ ]  Unknown | Date first began      | Date of last use      |
| Has this patient been informed of his/her HIV infection? [ ]  Yes [ ]  No [ ]  Unknown |  |
|  | Test Result | Date of Test |
| Has patient been tested for syphilis? [ ]  Yes [ ]  No [ ]  Unknown | [ ]  Positive [ ]  Negative [ ]  Unknown |       |
| Has patient been tested for hepatitis C? [ ]  Yes [ ]  No [ ]  Unknown | [ ]  Positive [ ]  Negative [ ]  Unknown |       |
| Has patient been tested for TB? [ ]  Yes [ ]  No [ ]  Unknown | [ ]  Positive [ ]  Negative [ ]  Unknown |       |
| **For Female Patients (record all dates as mm/dd/yyyy)** |
| This patient is receiving or has been referred for gynecological or obstetrical services: [ ]  Yes [ ]  No [ ]  Unknown | Is this patient currently pregnant?[ ]  Yes [ ]  No [ ]  Unknown | Has this patient delivered live-born infants?[ ]  Yes [ ]  No [ ]  Unknown |
| If patient is currently pregnant,estimated date of delivery:  |       | If currently pregnant, has patient been referred to the Wisconsin HIV Primary Care Support Network? [ ]  Yes [ ]  No [ ]  Unknown Date of referral:       |

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| **DHS USE ONLY** |
| Date Received at Health Department | Partner Services Referral Completed      | Name - Agency / Field Worker      |
| WI HIV County      | RVCT Number      |
| Other State Numbers      |

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| **COMMENTS** |
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|  | Complete and return in an envelope marked “CONFIDENTIAL” to:**Scott Stokes**Division of Public HealthPO Box 2659MADISON WI 53701-2659Fax to 608-266-1288 or call 608-267-5287 with information or questions (ask to be connected with a Surveillance Specialist). |  |
| Confirmed and suspect cases of HIV infection and AIDS are required to be reported to the Division of Public Health per Wis. Stat. § 252.05. Information provided is confidential as required per Wis. Stat. § 252.15.Disclosure of Social Security Number is voluntary. The Social Security Number and other information on this form are used for surveillance, control and prevention of HIV infections. The information is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated and will not otherwise be disclosed or released without the consent of the individual. |