

**New Jersey Department of Health and Senior Services**  
**ADULT HIV/AIDS CONFIDENTIAL CASE REPORT**  
**(FOR PATIENTS ≥ 13 YEARS OF AGE AT TIME OF DIAGNOSIS)**

Date Received at NJDHSS
-------------------------

(IMPORTANT: Fields which are "shaded" are required fields and MUST be completed.)

PATIENT NAME AND ADDRESS				
Patient Name (Last, First, MI)		Alias		Telephone No.
Address		City		State Zip Code
County	Date Form Completed	Prisoner Number	CTS Number	Medical Record Number

NJDHSS USE ONLY		
Soundex Code	Reporting Health Department-State	State Patient Number
Surveillance Method <input type="checkbox"/> A <input type="checkbox"/> F <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> U	Reporting Health Department-City/County	
Document Source		Or Source Code A . . . . .
Did this Report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Report Medium <input type="checkbox"/> Field Visit <input type="checkbox"/> Mailed <input type="checkbox"/> Telephone <input type="checkbox"/> SDN	

DEMOGRAPHIC INFORMATION				
Diagnostic Status at Report <input type="checkbox"/> HIV Infection (not AIDS) <input type="checkbox"/> AIDS	Date of Birth (Month/Day/Year) ___ / ___ / ___	Alias Date of Birth (Month/Day/Year) ___ / ___ / ___	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Country of Birth <input type="checkbox"/> U.S. <input type="checkbox"/> Other, Specify:
Ethnicity (Select One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown	Race (Select one or more) <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pac. Isl. <input type="checkbox"/> Unknown			
Current Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead	Date of Death ___ / ___ / ___	State/Territory of Death		

RESIDENCE AT DIAGNOSIS			
City	County	State/Country	Zip Code _____ - _____

FACILITY/PROVIDER OF DIAGNOSIS			
Name of Facility/Provider		Name of Contact Person	
Facility/Provider Full Address		Name of Person Completing Form	
City	State	Zip Code	Main Telephone Number
Facility Setting (Check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Unknown		Facility Type (Check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other, Specify:	

PATIENT HISTORY						
Yes	No	Unk		Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injected nonprescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HETEROSEXUAL relations with any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous/injection drug user	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bisexual male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Person with hemophilia/coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion recipient with documented HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplant recipient with documented HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Person with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perinatal infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CLINICAL STATUS			
Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Co-Infection: <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> STD (Specify): _____	Date Patient was Diagnosed as <b>Asymptomatic</b> (including acute retroviral syndrome and persistent generalized lymphadenopathy): ___ / ___ / ___	Date Patient was Diagnosed as <b>Symptomatic</b> (not AIDS): ___ / ___ / ___

**ADULT HIV/AIDS CONFIDENTIAL CASE REPORT (Continued)**

**LABORATORY DATA**

**HIV Antibody Tests at Diagnosis**

HIV-1 Western Blot      Pos   Neg         /   /     
 Rapid \_\_\_\_\_      Pos   Neg         /   /     
 Rapid \_\_\_\_\_      Pos   Neg         /   /     
 HIV-1 EIA              Pos   Neg         /   /     
 HIV-1/2 EIA            Pos   Neg         /   /     
 HIV-2 EIA              Pos   Neg         /   /     
 HIV-2 Western Blot    Pos   Neg         /   /   

**Positive HIV Detection Test (Record Earliest Test)**

Culture   Antigen   PCR, DNA or RNA probe         /   /     
Other (Specify): \_\_\_\_\_         /   /   

**Viral Load Test (Earliest and Most Recent Tests)**

Test Type	Copies/ml or Undetectable	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> NASBA	_____	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> RT-PCR	_____	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> bDNA	_____	<u>   /   /   </u>	<u>   /   /   </u>
Test Type	Copies/ml or Undetectable	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> NASBA	_____	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> RT-PCR	_____	<u>   /   /   </u>	<u>   /   /   </u>
<input type="checkbox"/> bDNA	_____	<u>   /   /   </u>	<u>   /   /   </u>

Date of last documented Negative HIV test (specify type):    /   /     
 IF HIV lab tests were not documented, is HIV diagnosis documented by a physician?   Yes   No   Unk.  
 If yes, provide date of documentation by physician:    /   /   

**Prior Tests**

**No. of HIV tests in 2 years before first positive:** \_\_\_\_\_

**Immunologic Lab Tests**

At or closest to current diagnostic status:  
 CD4 Count ..... cells/ $\mu$ L         /   /     
 CD4 Percent ..... %         /   /     
 First <200  $\mu$ L or 14%  
 CD4 Count ..... cells/ $\mu$ L         /   /     
 CD4 Percent ..... %         /   /   

**Genotype Testing**

Yes   No   Lab: \_\_\_\_\_      Date:    /   /   

**AIDS INDICATOR DISEASES**

AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)	AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)
	Def.*	Pres.*			Def.*	Pres.*	
Candidiasis, bronchi, trachea, or lungs		N/A	<u>   /   </u>	Lymphoma, Burkitt's (or equivalent term)		N/A	<u>   /   </u>
Candidiasis, esophageal			<u>   /   </u>	Lymphoma, immunoblastic (or equivalent term)		N/A	<u>   /   </u>
Carcinoma, invasive cervical		N/A	<u>   /   </u>	Lymphoma, primary in brain		N/A	<u>   /   </u>
Coccidioidomycosis, disseminated or extrapulmonary		N/A	<u>   /   </u>	<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary			<u>   /   </u>
Cryptococcosis, extrapulmonary		N/A	<u>   /   </u>	<i>M. tuberculosis</i> , pulmonary **			<u>   /   </u>
Cryptosporidiosis, chronic intestinal (>1 mo. Duration)		N/A	<u>   /   </u>	<i>M. tuberculosis</i> , disseminated or extrapulmonary **			<u>   /   </u>
Cytomegalovirus disease (other than in liver, spleen, or nodes)		N/A	<u>   /   </u>	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary			<u>   /   </u>
Cytomegalovirus retinitis (with loss of vision)		N/A	<u>   /   </u>	<i>Pneumocystis carinii</i> pneumonia			<u>   /   </u>
HIV encephalopathy		N/A	<u>   /   </u>	Pneumonia, recurrent, in 12 mo. Period			<u>   /   </u>
Herpes simplex: chronic ulcer(s) (>1 mo. Duration), or bronchitis, pneumonitis or esophagitis		N/A	<u>   /   </u>	Progressive multifocal leukoencephalopathy		N/A	<u>   /   </u>
Histoplasmosis, disseminated or extrapulmonary		N/A	<u>   /   </u>	Salmonella septicemia, recurrent		N/A	<u>   /   </u>
Isosporiasis, chronic intestinal (>1 mo. Duration)		N/A	<u>   /   </u>	Toxoplasmosis of brain			<u>   /   </u>
Kaposi's sarcoma			<u>   /   </u>	Wasting syndrome due to HIV		N/A	<u>   /   </u>

\* Def. = Definitive Diagnosis      Pres. = Presumptive Diagnosis      \*\* RVCT Case No.: \_\_\_\_\_

**TREATMENT/SERVICES REFERRALS**

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of patient's sex or needle sharing partners: _____	Number of patient's partners notified about their HIV exposure by provider: _____
Is this patient receiving or has been referred for: HIV related medical services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Substance abuse treatment services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	This patient received or is receiving: Antiretroviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown PCP prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
This patient has been enrolled at (clinical trial)? <input type="checkbox"/> NIH Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	This patient has been enrolled at (clinic)? <input type="checkbox"/> HRSA Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
At time of HIV/AIDS diagnosis, medical treatment primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance/HMO <input type="checkbox"/> No Coverage <input type="checkbox"/> Other Public Funding <input type="checkbox"/> Clinical Trial/Government Program <input type="checkbox"/> Unknown		

**FOR MEN:**

Is this patient circumcised?  
Yes   No   Unknown  
 If Yes, patient's age at circumcision: \_\_\_\_\_

**FOR WOMEN:**

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 since 1989?   Yes (If yes, provide birth information below.)   No   Unknown

Child's DOB (Mo/Day/Yr.)	Name of Child	Hospital	City	State	Child's Soundex	Child's State No.

Comments