

PATIENT INFORMATION

Patient Name¹ (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 diagnosis² Inpatient diagnosis ER diagnosis

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

Outpatient diagnosis² 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: _____

**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

HIV DIAGNOSTIC TESTS

Type of Test <i>At least 2 antibody tests must be indicated for an HIV diagnosis IA = Immunoassay</i>	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 (4 th Gen)	___/___/___				
HIV-1/2 EIA IA (2 nd or 3 rd Gen)	___/___/___				
HIV 1 and 2 Type Differentiating IA (Supplemental Ab Test)	___/___/___		<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Undiff	<input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2	<input type="checkbox"/> HIV-1 <input type="checkbox"/> 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 TESTS⁴

HIV VIRAL LOAD TESTS			CD4 LEVELS			
	Test Date	Copies/ml		Test Date	Count	%
Earliest HIV viral load	___/___/___	_____	Earliest CD4	___/___/___	_____ cells/μl	_____ %
Most recent HIV viral load	___/___/___	_____	Most recent CD4	___/___/___	_____ cells/μl	_____ %
EARLIEST DRUG RESISTANCE TEST						
Date: ___/___/___	<input type="checkbox"/> Genotype <input type="checkbox"/> Phenotype	First CD4 <200 μl	___/___/___	_____ cells/μl	_____ %	
Laboratory: _____						

PATIENT HISTORY SINCE 1977³

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



OPPORTUNISTIC ILLNESSES ^{4,5}			
	Diagnosis date		Diagnosis date
<input type="checkbox"/> Candidiasis, esophageal	___/___/___	<input type="checkbox"/> Kaposi's sarcoma	___/___/___
<input type="checkbox"/> Cryptococcosis, extrapulmonary	___/___/___	<input type="checkbox"/> PCP/PJP (Pneumocystis pneumonia)	___/___/___
<input type="checkbox"/> Cytomegalovirus disease (other than in liver, spleen, nodes)	___/___/___	<input type="checkbox"/> Wasting syndrome due to HIV	___/___/___
<input type="checkbox"/> Herpes simplex: chronic ulcer(s) (>1 mo. duration) bronchitis, pneumonitis or esophagitis	___/___/___	<input type="checkbox"/> Other(s): _____	___/___/___



Please return completed form to:
Washington State Department of Health
Office of Infectious Disease
Assessment Unit
PO Box 47838, Olympia, WA 98504-7838
(360) 236-3464



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

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	NEGATIVE HIV TESTS
Ever had a previous positive test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Ever had a negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date of first positive test: ___/___/___	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):
<input type="checkbox"/> HIV Treatment.....	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
<input type="checkbox"/> PREP.....	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
<input type="checkbox"/> PEP	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
<input type="checkbox"/> PCP Prophylaxis..	<input type="checkbox"/> Bactrim <input type="checkbox"/> Other _____	___/___/___	<input type="checkbox"/> Yes	___/___/___
<input type="checkbox"/> Other ARV.....	<input type="checkbox"/> _____	___/___/___	<input type="checkbox"/> 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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
This patient is receiving/has been referred for:				
• HIV related medical service.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV Social Service Case Management.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Substance abuse treatment services.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR WOMEN

Is patient currently pregnant?
 No
 Unknown
 Yes → Expected delivery date:
 ___/___/___

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**

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) Filipino/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) Jordanian
- 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) Moroccan
- 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) Ukrainian
- OOO) Vietnamese
- PPP) White
- QQQ) Yemeni
- RRR) Other Race
- SSS) Patient declined to answer
- TTT) Unkown



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