



# CONFIDENTIAL INFORMATION - HIV/AIDS REPORT



Reporting Institution / Practice / Clinic \_\_\_\_\_  
Person completing form: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT NAME** (Last, F, M) \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ Sex \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_ Phone \_\_\_\_\_ Race / Ethnicity \_\_\_\_\_  
 Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Med. Rec. No. \_\_\_\_\_ Country of Birth \_\_\_\_\_  
 If Patient Expired: Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Death \_\_\_\_\_  
 Date of First Visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Most Recent Visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Other who can provide information (Hospital, Doctor, Clinic) \_\_\_\_\_

**How patient became HIV-infected: (✓ all that apply)**

- \_\_\_\_ Male who had sex with another male
- \_\_\_\_ Injection drug user
- \_\_\_\_ Sex with partner of opposite sex who is: (✓)
  - \_\_\_\_ Injection drug user
  - \_\_\_\_ Bisexual male
  - \_\_\_\_ Hemophiliac
  - \_\_\_\_ Person with HIV/AIDS
  - \_\_\_\_ Other (specify) \_\_\_\_\_
- \_\_\_\_ Blood/blood product recipient, date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Facility where transfused \_\_\_\_\_
- \_\_\_\_ Treatment of hemophilia: Factor VIII (A) \_\_\_\_ Factor IX (B) \_\_\_\_
- \_\_\_\_ Occupational exposure (give details) \_\_\_\_\_
- \_\_\_\_ No risk identified or patient denied all risk behavior  
 date patient was interviewed (Mo/Yr) \_\_\_\_/\_\_\_\_

| HIV Test Results (+)   | Date  | Facility | CD4 Test                                 | Results | Date     | Facility |
|--|-------|----------|--|---------|----------|----------|
| 1 <sup>st</sup> ELISA  | _____ | _____    | First CD4 < 200 (cells/mm <sup>3</sup> ) | _____   | _____    | _____    |
| 1 <sup>st</sup> Western Blot   | _____ | _____    | First CD4 percent < 14 (%)               | _____   | _____    | _____    |
| 1 <sup>st</sup> WB after 1998  | _____ | _____    | First CD4 count (cells/mm <sup>3</sup> ) | _____   | _____    | _____    |
| Other  | _____ | _____    | First CD4 percent (%)                    | _____   | _____    | _____    |
| 1 <sup>st</sup> detectable Viral Load after Dec. 1999(copies/mm <sup>3</sup> ) |       |          | Date                                     | _____   | Facility | _____    |

**If patient has had an opportunistic infection (O.I.) or neoplasm, please fill in blanks.** (See other side of form for list.)

O.I./Neoplasm \_\_\_\_\_ Method of Diagnosis \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_

O.I./Neoplasm \_\_\_\_\_ Method of Diagnosis \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_

If patient is a woman:

(a) Patient receiving or referred for OB/GYN services: Yes \_\_\_\_ No \_\_\_\_ Unknown \_\_\_\_

(b) Patient delivered live-born infant(s) after 1977: Yes \_\_\_\_ No \_\_\_\_ Unknown \_\_\_\_

If Yes, and information is available, enter each child's name, DOB, and hospital of delivery on back of this form.

(c) Patient currently pregnant: Yes \_\_\_\_ No \_\_\_\_ Due Date \_\_\_\_\_

**Has this patient been notified of his/her HIV infection?**

Yes \_\_\_\_ No \_\_\_\_ Unknown \_\_\_\_

**This patient's partners will be notified about their HIV exposure and counseled by:**

Health Dept. \_\_\_\_ Doctor/provider \_\_\_\_ Patient \_\_\_\_ Unknown \_\_\_\_

**This patient is receiving or has been referred for:**

HIV related medical services: Yes \_\_\_\_ No \_\_\_\_ Unknown \_\_\_\_

Substance abuse treatment services:  
 Yes \_\_\_\_ No \_\_\_\_ Not applicable \_\_\_\_ Unknown \_\_\_\_

**NOTES:**

**Date of first diagnosis:** \_\_\_\_\_

**Where:** \_\_\_\_\_  
 Facility \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Other Significant Information:**

## **OPPORTUNISTIC INFECTIONS and NEOPLASMS**

(If patient has any of these diagnoses, enter on front of form.)

### **PATIENTS OF ALL AGES**

Candidiasis, bronchi, trachea or lungs  
Candidiasis, esophageal  
Carcinoma, invasive cervical  
Coccidioidomycosis, disseminated or extrapulmonary  
Cryptococcosis, extrapulmonary  
Cryptosporidiosis, chronic intestinal (>1 month)  
CMV disease (please specify anatomical site)  
CMV retinitis  
HIV encephalopathy (AIDS dementia complex)  
Herpes simplex chronic ulcer (>1 month)  
Herpes simplex bronchitis, pneumonitis or esophagitis  
Histoplasmosis, disseminated or extrapulmonary  
Isosporiasis, chronic intestinal (>1 month)  
Kaposi's sarcoma  
Lymphoma, primary in brain  
Lymphoma, other (please specify the pathology)  
*M. avium* or *M. kansasii*, disseminated or extrapulmonary  
*M. tuberculosis*, pulmonary  
*M. tuberculosis*, disseminated or extrapulmonary  
*Mycobacterium*, other/unknown, dissem. or extrapulmonary  
*Pneumocystis carinii* pneumonia (PCP)  
Pneumonia, recurrent (two or more in 12 month period)  
Progressive multifocal leukoencephalopathy (PML)  
*Salmonella* septicemia, recurrent  
Toxoplasmosis of brain  
Wasting syndrome due to HIV

### **PATIENTS LESS THAN 13 YEARS OLD ONLY**

Bacterial infections, multiple, recurrent  
Lymphoid interstitial pneumonia and/or  
pulmonary lymphoid hyperplasia

**For resident of Harris County, send report to:**

Houston Department of Health and Human Services  
HIV/AIDS Surveillance, 4<sup>th</sup> Floor  
8000 North Stadium Drive  
Houston, TX 77054  
(832)393-5080

**For resident of Galveston, Chambers or Brazoria County, send report to:**

Galveston County Health District  
P.O. Box 838  
Galveston, TX 77553  
(409) 765-2528

**For resident of Austin, Colorado, Fort Bend, Hardin, Jefferson, Liberty, Matagorda, Montgomery, Orange, Walker, Waller or Wharton County, send report to:**

Texas Department of Health PHR 6/5 South  
STD Department  
5425 Polk Ave., Ste. J  
Houston, TX 77023-1497  
(713) 767-3420