|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES (DHS)**  Division of Public Health  F-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 America  DHS 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 | | |
|  | | | | | | | | | | | | | | | | | | | | | | - | | | | | | | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FACILITY OF DIAGNOSIS** | | | | | | | | | | | | | | |
| **Check if SAME as Facility Providing Information and go to the Next Section** | | | | | | | | | | | | | | |
| Facility Name | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| City | | | City | | | | | | City | | | | City | |
|  | | |  | | | | | |  | | | |  | |
| Facility  Type | **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 insemination  Date 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 | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Test  Specify: | | | | | |  | |  | |  | |  | | | | |
| **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 | | | | | | | | | | | | |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | |

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

|  |  |  |
| --- | --- | --- |
| **COMMENTS** | | |
|  | | |
|  | | |
|  | Complete and return in an envelope marked “CONFIDENTIAL” to:  **Scott Stokes**  Division of Public Health  PO Box 2659  MADISON WI 53701-2659  Fax 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. | | | |