HOUSTON
Adult HIV/AIDS Confidential
Case Reporting Form (ACRF)
(>13 years of age at time of diagnosis)

State Patient Number: ☐☐☐☐☐☐☐☐☐☐

City/County Patient Number: ☐☐☐☐☐☐☐☐☐☐

For HDHHS Staff Use Only

Date Received at HDHHS: ____/____/____

Document Source (Fac. Type): __________

Did this report/document initiate a new investigation? ☐ Yes ☐ No

If this report/document is an epidemiological follow-up, enter the document it is linked to:

Surveillance Method:
- ☐ Active
- ☐ Follow up
- ☐ Passive
- ☐ Re-abstraction
- ☐ Unknown

Report Medium:
- ☐ Paper form field visit
- ☐ Paper form mailed
- ☐ Telephone
- ☐ Electronic
- ☐ Diskette
- ☐ Other

ACRF Information

Date Form Completed:______/______/__________

Person Completing Form: ____________________

Facility Completing Form

Facility Name: ____________________________

Facility Type: ____________________________

City: ______________ State: ____________

Identification

Patient's Name: (First, Middle, Last) | Alias: (First, Middle, Last)

Address: | City: | County: | State: | Zip Code:

Telephone # | SSN# | Medical Record # | SPN #

Demographic Information

Diagnostic Status At Report	Sex at Birth	Date of Birth	Alias Date of Birth	Country of Birth	Vital Status	Date of Death
☐ Adult HIV ☐ Adult AIDS	☐ Male ☐ Female ☐ Unknown	Mo. ☐☐ Day ☐☐ Year ☐☐	Mo. ☐☐ Day ☐☐ Year ☐☐	☐ U.S. ☐ Unknown ☐ Other (Specify:) ________	☐ Alive ☐ Dead ☐ Unknown	Mo. ☐☐ Day ☐☐ Year ☐☐ State of Death ________

Ethnicity	Transgender	Race
☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown	☐ Male to Female ☐ Female to Male ☐ Other _______	☐ American Indian or Alaska Native ☐ Native Hawaiian ☐ White ☐ Black or African American ☐ Asian ☐ Unknown

Residence at Diagnosis

HIV: Address: | City | County: | State: | Zip Code:

AIDS: Address: | City | County: | State: | Zip Code:

Facility and Provider of Diagnosis

Facility of HIV Diagnosis

Facility Name: ______________________________

City/State/Country: __________________________

Facility Type: ______________________________

Provider: __________________________________

Facility of AIDS Diagnosis

Facility Name: ______________________________

City/State/Country: __________________________

Facility Type: ______________________________

Provider: __________________________________

Patient History / Risk Factor Description

After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis, this patient had:	*Yes*	*No*	*Unk.*
Sex with male	☐	☐	☐
Sex with female	☐	☐	☐
Injected non-prescription drugs	☐	☐	☐
Received clotting factor for hemophilia / coagulation disorder	☐	☐	☐
Heterosexual relations with any of the following:			
Heterosexual contact with intravenous/injection drug user	☐	☐	☐
Heterosexual contact with bisexual male	☐	☐	☐
Heterosexual contact with person with hemophilia / coagulation disorder	☐	☐	☐
Heterosexual contact with transfusion recipient with documented HIV infection	☐	☐	☐
Heterosexual contact with transplant recipient with documented HIV infection	☐	☐	☐
Heterosexual contact with person with AIDS or documented HIV infection, risk not specified	☐	☐	☐
Received transfusion of blood / blood components (other than clotting factor)	☐	☐	☐
Received transplant of tissue / organs or artificial insemination	☐	☐	☐
Worked in a health care or clinical laboratory setting	☐	☐	☐
Other documented risk	☐	☐	☐

Laboratory Data

HIV Antibody Test at Diagnosis (Indicate first test)

Test				Collection Date *(mm/dd/yyyy)*
Rapid HIV1/2 / ________	☐ **Positive**	☐ **Negative**	☐ **Indeterminate**	____/____/________
HIV-1/2 Ag/Ab	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
HIV-1/2 EIA	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
HIV-1 Western Blot	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
HIV-1 IFA	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
Geenius ____	☐ HIV-1	☐ HIV-2	☐ Both	____/____/________
	☐ Negative	☐ Indeterminate		
BioPlex AG/AB ASSAY ____	☐ Reactive	☐ Non Reactive	☐ Indeterminate	____/____/________
HIV-1 ANTIBODY:	☐ Reactive	☐ Non Reactive	☐ Indeterminate	____/____/________
HIV-1 ANTIGEN:	☐ Reactive	☐ Non Reactive	☐ Not Reportable Due to High Leve of Antibodies	____/____/________
HIV2-ANTIBODY:	☐ Reactive	☐ Non Reactive	☐ Indeterminate	____/____/________
Other ________________	☐ Reactive	☐ Non Reactive	☐ Indeterminate	____/____/________

HIV Detection Test (Record all tests)

Test				Collection Date *(mm/dd/yyyy)*
HIV-1 P24 Antigen	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
HIV-1 RNA PCR (Qualitative NAAT)	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________
Other ________________	☐ Positive	☐ Negative	☐ Indeterminate	____/____/________

Immunologic Lab Tests

Test		Collection Date *(mm/dd/yyyy)*
CD4 Counts	________ cells/ul	____/____/________
CD4 Percent	________ %	____/____/________

Viral Load Tests (Most recent test)	**Copies/ul**	**Log**	**Collection Date** *(mm/dd/yyyy)*
HIV-1 RNA RT-PCR	________	________	____/____/________

Last documented negative HIV test? Date ______/______/__________ Test Type ________________________

If HIV laboratory test not documented, Is HIV diagnosis documented by a physician? ☐Yes ☐No ☐Unknown If Yes, Date ____/____/________

Clinical

Clinical Record Reviewed: ☐ **Yes** ☐ **No**

Enter date patient was diagnosed as:

Asymptomatic: ____/____/________

Symptomatic (not AIDS): ____/____/________

AIDS Indicator Diseases (O. I.)

	Def	Pres	Initial Date
O. I. ________________________	☐	☐	____/____/____
O. I. ________________________	☐	☐	____/____/____
O. I. ________________________	☐	☐	____/____/____
O. I. ________________________	☐	☐	____/____/____
O. I. ________________________	☐	☐	____/____/____

Others

For M. tuberculosis, pulmonary, RVCT Case Number: ________________

If HIV tests were not positive or were not done, does the patient have an immunodeficiency that would disqualify him/her from AIDS case definition? ☐ Yes ☐ No ☐ Unknown.

Treatment / Services Referrals

Has this patient been **informed** of his/her infection?	☐Yes	☐ No	☐ Unknown	
This patient's **partners will be notified** about their HIV exposure and counseled by:	☐Health Department	☐Physician/Provider	☐Patient	☐Unknown
This patient is receiving or has been referred for HIV related **medical services**:	☐Yes	☐No	☐N/A	☐Unknown
This patient is receiving or has been referred for **substance abuse** treatment services:	☐Yes	☐No	☐N/A	☐Unknown
This patient received or is receiving **antiretroviral therapy (ART):**	☐Yes	☐No	☐Unknown	
This patient received or is receiving **PCP prophylaxis**:	☐Yes	☐No	☐N/A	☐Unknown

For Women

This patient is receiving or has been referred for gynecological or obstetrical services:	☐Yes	☐No	☐Unknown
Is this patient currently pregnant? LMP:________ EDD::__________ EGA:__________	☐Yes	☐No	☐Unknown
Has this patient delivered live-born infants?	☐Yes	☐No	☐Unknown (If yes, provide birth info below)

Child's Name: ______________________________ Child's State ID Number: ______________ Child's Date of Birth: ____/____/________

Child's Hospital of Birth: ______________ City: ______________ State: __________County: ______________ Country: ______________

Testing and Treatment History (TTH)

Completion Method: ☐ ***Patient Interview*** ☐ ***MRR*** ☐ ***Provider Report*** ☐ ***PEMS*** ☐ ***Other*** ***Date information is collected:*** ____/____/________

EVER had previous positive HIV test? ☐Yes ☐No ☐Refused ☐Unk Date of very first positive HIV test: ____/____/________

EVER had a negative HIV test? ☐Yes ☐No ☐Refused ☐Unk Date of very last negative HIV test: ____/____/________

Number of negative HIV tests within 24 months before first positive ________ ☐ Refused ☐ Unk

(Dates of negative tests: ___/___/_____; ___/___/_____; ___/___/_____; ___/___/_____ ___/___/_____; ___/___/_____; ___/___/_____)

Ever taken any ARV? ☐Yes ☐No ☐ Refused ☐Unk **If yes, Name all ARV:**__

____

Date 1st use: ___/___/_______ **Date of last use :**___/___/_______

Local Fields (For Office Use Only)

Field Record cut for PHFU: ☐Yes (cut by HIV surveillance staff) Date FR cut ___/___/________ ☐Other (cut by others) ☐No