



Illinois Department of Public Health
Adult HIV/AIDS Confidential Case Report
(Patients ≥ 13 years of age at time of diagnosis)

I. Patient Information

Form section for Patient Information including fields for name, address, city, county, state, ZIP code, phone number, and social security number.

II. Facility Completing Form

Form section for Facility Completing Form including fields for date completed, medical record number, person completing form, facility type, and address.

III. Health Department Use Only

Form section for Health Department Use Only including fields for document source, date received, surveillance method, and reporting health department details.

IV. Demographic Information

Form section for Demographic Information including fields for diagnostic status, date of birth, marital status, education, sex assigned at birth, current gender identity, ethnicity, race, and residence at diagnosis.

V. Facility and Provider of Diagnosis				
<input type="checkbox"/> AIDS diagnosis <input type="checkbox"/> HIV diagnosis		Facility name		
Address		City	County	State/Country ZIP code
Facility setting <input type="checkbox"/> Public <input type="checkbox"/> Federal (specify): _____ <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Private		Facility type <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Laboratory <input type="checkbox"/> Counseling and testing <input type="checkbox"/> Outpatient/HIV clinic <input type="checkbox"/> Emergency room <input type="checkbox"/> Other screening, diagnostic, referral site <input type="checkbox"/> Outpatient/Other <input type="checkbox"/> STD clinic <input type="checkbox"/> Unknown <input type="checkbox"/> Correctional <input type="checkbox"/> Other (specify): _____		HRSA funding <input type="checkbox"/> None <input type="checkbox"/> Title IV <input type="checkbox"/> Title I <input type="checkbox"/> SPNS <input type="checkbox"/> Title II <input type="checkbox"/> Other <input type="checkbox"/> Title III <input type="checkbox"/> Unknown
Provider name			Provider specialty	Provider phone number

VI. Patient History					
Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories):			YES	NO	UNK.
• Sex with male					
• Sex with female					
• Injected non-prescription drugs					
• Received clotting factor for hemophilia/coagulation disorder					
Specify clotting factor: _____ Date received (mm/dd/yyyy) _____					
• Heterosexual relations with any of the following:					
○ Intravenous/injection drug user					
○ Bisexual male					
○ Person with hemophilia/coagulation disorder					
○ Transfusion recipient with documented HIV infection (consider documenting reason in the comments section)					
○ Transplant recipient with documented HIV infection (consider documenting reason in the comments section)					
○ Person with AIDS or documented HIV infection, risk not specified					
• Received transfusion of blood/blood components (other than clotting factor) (document reason in comments section)					
First date received _____ Last date received _____					
• Received transplant of tissue/organs or artificial insemination					
• Worked in a health care or clinical laboratory setting					
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____					
• Other documented risk					
• No identified risk factor (NIR)					

VII. Laboratory Data			
HIV Antibody Tests at Diagnosis (indicate first test—mm/dd/yyyy date)			
HIV-1 EIA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	HIV-1/2 EIA
			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			____/____/____
HIV-1 Western Blot	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	HIV-2 EIA
			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			____/____/____
Rapid	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	HIV-2 Western Blot
			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			____/____/____
HIV-1 IFA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	
HIV Detection Tests (record all tests—mm/dd/yyyy date)			
HIV-1 P24 Antigen	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	HIV-1 Proviral DNA (Qual)
			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			____/____/____
HIV-1 RNA PCR (Qual)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	HIV-2 Culture
			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			____/____/____
HIV-1 Culture	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	____/____/____	
Immunologic Lab Tests (record additional CD4 tests in comments section)			
At or closest to current diagnostic status		CD4 count	cells/μL
		CD4 percent	%
		____/____/____	____/____/____
First <200μL or <14%		CD4 count	cells/μL
		CD4 percent	%
		____/____/____	____/____/____
Viral Load Tests (record only detectable viral load tests; record additional viral load tests in comments section)			
		Copies/μL	Log
		Collection date (mm/dd/yyyy)	
HIV-1 RNA NASBA		____/____/____	
HIV-1 RNA RT-PCR		____/____/____	
HIV-1 RNA bDNA		____/____/____	
HIV-1 RNA Other		____/____/____	
Date of last documented negative HIV test		Specify type of test: _____	
____/____/____		If YES, enter date of diagnosis (mm/dd/yyyy): _____	
Is HIV diagnosis documented by a physician?		____/____/____	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

VIII. Clinical Status																			
Clinical record reviewed		<input type="checkbox"/> Yes <input type="checkbox"/> No		Enter date patient was diagnosed as:				Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy)		mm/dd/yyyy		Symptomatic (not AIDS)		mm/dd/yyyy					
AIDS Indicator Diseases				Initial Dx		Initial Date		AIDS Indicator Diseases				Initial Dx		Initial Date					
				Def.		Pres.		mm/dd/yyyy						Def.		Pres.		mm/dd/yyyy	
Candidiasis, bronchi, trachea, or lungs										Lymphoma, Burkitt's (or equivalent)									
Candidiasis, esophageal										Lymphoma, immunoblastic (or equivalent)									
Carcinoma, invasive cervical										Lymphoma, primary in brain									
Coccidioidomycosis, disseminated or extrapulmonary										Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary									
Cryptococcosis, extrapulmonary										M. tuberculosis, pulmonary									
Cryptosporidiosis, chronic intestinal (>1 mo. duration)										M. tuberculosis, disseminated or extrapulmonary									
Cytomegalovirus disease (other than in liver, spleen, or nodes)										Mycobacterium, of other/unidentified species, disseminated or extrapulmonary									
Cytomegalovirus retinitis (with loss of vision)										Pneumocystis carinii pneumonia									
HIV encephalopathy										Pneumonia, recurrent, in 12 mo. period									
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis										Progressive multifocal leukoencephalopathy									
Histoplasmosis, disseminated or extrapulmonary										Salmonella septicemia, recurrent									
Isosporiasis, chronic intestinal (>1 mo. duration)										Toxoplasmosis of brain, onset at >1 mo. of age									
Kaposi's sarcoma										Wasting syndrome due to HIV									
Lymphoid interstitial pneumonia and/or pulmonary lymphoid										Def. = definitive diagnosis								Pres. = presumptive diagnosis	
RVCT case number																			
If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition:										<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown					

IX. 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		This patient's partners will be notified about their HIV exposure and counseled by:				<input type="checkbox"/> Health department <input type="checkbox"/> Physician/Provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown					
This patient is receiving or has been referred for:				HIV-related medical services		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		This patient received or is receiving:				Antiretroviral therapy		<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						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 diagnosis, medical treatment primarily reimbursed by:						At time of AIDS diagnosis, medical treatment primarily reimbursed by:									
For Female Patient															
This patient is receiving or has been referred for gynecological or obstetrical services:						<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown					
Is this patient currently pregnant?						<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown					
Has this patient delivered live-born infants?						<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown					
For Children of Patient (record most recent birth in these boxes; record additional or multiple births in the comments section)															
Child's name						Child's date of birth									
Child's first Soundex				Child's last Soundex				Child's state number							
Child's coded ID															
Hospital of Birth (if child was born at home, enter "home birth" for hospital name)															
Hospital name															
Address															
City				County				State				ZIP			
Country															

