HIV Surveillance Program

Bureau of HIV/STI/Viral Hepatitis

Department of Health

OHIO ADULT HIV CASE REPORT FORM

(Patients ≥13 years of Age at Time of Diagnosis)

PATIENT IDENTIFICATION

First Name:	Middle Name:	Last Name:	Alias:

Address Type: ☐ Residential ☐ Jail (City or County) ☐ Unhoused ☐ Prison (State or Federal) ☐ Drug Treatment Facility ☐ Other

Street Address:

City:	County:	State / Country:	ZIP:

Phone:	Social Security # (Last Four):	Medical Record Number:

PATIENT DEMOGRAPHICS

Date of Birth:	Sex: ☐ Male ☐ Female ☐ Unknown	Vital Status: ☐ Alive ☐ Dead	Date of Death:

Country of Birth: ☐ US ☐ Other - Specify:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Race (Check all that apply): ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Asian ☐ Other ☐ Black / African American ☐ Middle Eastern or North African ☐ White ☐ Unknown

PREVIOUS POSITIVE INFORMATION (Only fill out if patient has previously tested positive for HIV)

Diagnosis Date:	State / Country of Diagnosis:	Diagnosing Facility:

LABORATORY DATA

Ordering Provider:	Ordering Facility:	Performing Laboratory:

HIV Screening Test at Diagnosis:

HIV-1/2 Screening: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

Point-of-Care Rapid HIV Test: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Confirmation / Differentiation (Geenius):

HIV-1: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV-2: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Viral Load Test - Quantitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D — **Copies/ml:** ☐ ND — **Collection Date:**

HIV Detection Tests - Qualitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

HIV-2 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

CD4 Tests:

Count:	Percent: %	Collection Date:

Resistance Tests:

Genotype Test Done? ☐ Yes ☐ No ☐ Unknown — **Collection Date:**

Other HIV Testing (Enter Any Additional HIV Tests):

Test Type:	Result:	Collection Date:

Past HIV Testing

Has this person ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown

If YES, date of the most recent negative test:

PATIENT HISTORY

Sex with male.	☐ Yes ☐ No ☐ Unknown
Sex with female.	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs or shared injection equipment.	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with a person who injects drugs.	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with bisexual male (for patient assigned female at birth only).	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with person living with HIV.	☐ Yes ☐ No ☐ Unknown
Other-specify:	

OPPORTUNISTIC INFECTIONS (Click here for common opportunistic infections)

Diagnosis(es) - list all that apply:	Diagnosis Date:

TREATMENT HISTORY

Has patient ever taken any antiretroviral medications (ARVs): ☐ Yes ☐ No ☐ Unknown	If YES, date ARV's last taken:
ARV's currently taking (list all that apply):	

FOR PREGNANT PATIENT OF CHILDBEARING POTENTIAL

Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown	If currently pregnant, estimated date of delivery:	Has the patient been referred for prenatal care? ☐ Yes ☐ No ☐ Unknown
Patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown	If delivered, most recent delivery date:	Child's Name:

Delivery Hospital:	City:	State:

FACILITY PROVIDING INFORMATION

Facility Name:		Street Address:	
City:	County:	State:	Zip Code:
Name of Provider that Ordered HIV Diagnostic Tests:		Specialty:	Phone Number:

PERSON PROVIDING INFORMATION

Date Form Completed:	Person Completing Form:	Phone Number/Email:

COMMENTS SECTION

Provide any additional information about the patient:

Complete and submit the case form by one of the following methods:

Fax: 614-388-9782

Mail the report form in an envelope marked "Confidential" to:

Ohio Department of Health
HIV Surveillance Program
246 N. High St
Columbus, OH 43215

If you have any questions, email HIVsurveillance@odh.ohio.gov.

All confirmed cases of HIV, including Stage 3 (AIDS), are required to be reported by healthcare providers and laboratories to the designated health authorities per Ohio Administrative Code 3701-3-12.