WISCONSIN HIV CASE REPORT

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

Diagnosis Status: ☐ Acute ☐ HIV ☐ Stage 3 (AIDS)

DHS State Number (DHS use only)

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

Phone – Primary	Phone – Secondary	Social Security Number*	Vital Status ☐ Alive ☐ Dead	Date of Death

PATIENT DEMOGRAPHICS (Record all dates as mm/dd/yyyy.)

Date of Birth	Country of Birth ☐ US ☐ Other – specify:	Preferred Language

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown

Current Gender Identity: ☐ Cisgender Man ☐ Transgender Man ☐ Unknown ☐ Cisgender Woman ☐ Transgender Woman ☐ Additional Gender Identity – specify:

Date Identified:

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

Race (Check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown

Sexual Orientation: ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Unknown ☐ Additional sexual orientation – specify:

Date Identified:

For Person of Childbearing Potential

This patient is receiving or has been referred for gynecological and/or obstetrical (OBGYN) services: ☐ Yes ☐ No ☐ Unknown	Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown	Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown
If currently pregnant, estimated date of delivery:	Has this patient been referred for prenatal care? ☐ Yes ☐ No ☐ Unknown Referral date: ☐ OBGYN ☐ WI HIV Primary Care Support Network	

RESIDENCE AT DIAGNOSIS

Street Address at HIV Diagnosis ☐ **Check if same as current address**	City	County	State/Country	Zip Code
Street Address at Stage 3 (AIDS) Diagnosis ☐ **Check if same as current address**	City	County	State/Country	Zip Code

FACILITY OF DIAGNOSIS

Facility Name		Street Address	
City	County	State/Country	Zip Code

Facility Type

Inpatient
- ☐ Hospital
- ☐ Other:

Outpatient
- ☐ Private Physician's Office
- ☐ Adult HIV Clinic
- ☐ VAMC
- ☐ Other:

Other Facility
- ☐ HIV Testing Site
- ☐ STD Clinic
- ☐ Blood/Plasma Center
- ☐ Family Planning Clinic

A#
- ☐ Emergency Room
- ☐ Corrections
- ☐ Other:

Name of Provider That Ordered HIV Diagnostic Tests	Specialty	Phone

FACILITY PROVIDING INFORMATION ☐ Check if SAME as Facility of Diagnosis and go to Person Providing Information

Facility Name		Street Address	
City	County	State/Country	Zip Code

Facility Type

Inpatient
- ☐ Hospital
- ☐ Other:

Outpatient
- ☐ Private Physician's Office
- ☐ Adult HIV Clinic
- ☐ VAMC
- ☐ Other:

Other Facility
- ☐ HIV Testing Site
- ☐ STD Clinic
- ☐ Blood/Plasma Center
- ☐ Family Planning Clinic

A#
- ☐ Emergency Room
- ☐ Corrections
- ☐ Other:

PERSON PROVIDING INFORMATION

Date Form Completed (mm/dd/yyyy)	Person Completing Form	Phone

PATIENT HISTORY (Check all that apply. Record additional risk information in Comments Section.)

This patient had:	
Sex with person assigned male at birth	☐ Yes ☐ No ☐ Unknown
Sex with person assigned female at birth	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs or shared injection equipment	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with person who injects drugs	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with bisexual person assigned male at birth (for patient assigned female at birth only)	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with person living with HIV, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transplant/transfusion/clotting disorder	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
Perinatally acquired HIV	☐ Yes ☐ No ☐ Unknown

OPPORTUNISTIC DIAGNOSES (Record additional diagnoses in Comments Section. Click here for common opportunistic diagnoses.)

	Diagnosis Date (mm/dd/yyyy)
Candidiasis, esophageal	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	
Kaposi's sarcoma	
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Pneumocystis pneumonia	
Wasting syndrome due to HIV	

LABORATORY DATA (Record dates as mm/dd/yyyy and additional tests and POC rapid HIV test types in Comments Section.)

HIV Screening Test at Diagnosis (Non-Differentiating/Differentiating)	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	☐	☐	☐	
Point-of-Care Rapid HIV Test 1	☐	☐	☐	
Point-of-Care Rapid HIV Test 2	☐	☐	☐	

HIV Antibody Test at Diagnosis (Differentiating/Supplemental)	Pos	Neg	Ind	Collection Date
HIV-1	☐	☐	☐	
HIV-2	☐	☐	☐	

HIV Detection/Viral Load Tests (Quantitative)	Copies/ml	Collection Date
First HIV-1 RNA/DNA NAAT		
Most recent HIV-1 RNA/DNA NAAT		
HIV-2 RNA NAAT		

HIV Detection Tests (Qualitative)		Collection Date
HIV-1 RNA/DNA NAAT (Nucleic Acid Amplification Test)	☐ Detectable ☐ Undetectable	
HIV-2 RNA NAAT (Nucleic Acid Amplification Test)	☐ Detectable ☐ Undetectable	
HIV 1-2 Dual NAAT	☐ HIV-1 ☐ HIV-2 ☐ Both ☐ Undetectable	

Immunologic Tests (CD4)

First CD4 <200 µL or <14%: Collection Date

Count | Percent %

Most Recent CD4:

Count | Percent %

Resistance Tests

Collection Date

Genotyping ☐ Yes ☐ No ☐ Unknown

Past HIV Testing

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

☐ Yes, medical record Date of test:

Test type:

☐ Yes, self-report Date of test:

Test type:

Has this patient ever had a positive HIV test? ☐ No

☐ Yes, medical record Date of test:

Test type:

☐ Yes, self-report Date of test:

Test type:

TREATMENT HISTORY

Has patient ever taken any antiretroviral medications (ARVs)?

☐ Yes ☐ No ☐ Unknown Date:

Has this patient been informed of their HIV diagnosis?

☐ Yes ☐ No ☐ Unknown

Reason for ARV use (select all that apply)

☐ HIV treatment ☐ Pre-exposure prophylaxis (PrEP)
☐ Post-exposure prophylaxis (PEP) ☐ Other reasons

ARVs ever taken (select all that apply) Click for full ARV list

☐ Atripla ☐ Biktarvy ☐ Cabenuva ☐ Descovy ☐ Genvoya ☐ Juluca
☐ Odefsey ☐ Prezista ☐ Symtuza ☐ Tivicay ☐ Triumeq ☐ Truvada
☐ Other:

What is the earliest date any ARVs were taken (including prior to diagnosis)?

What is the date of last ARV use?

COMMENTS SECTION

Complete and submit the case report form by one of the following (preferred in bold):
Submit electronically via Wisconsin Electronic Disease Surveillance System (WEDSS)
Fax to 608-720-3548
Call 608-267-5287 to leave a message (HIV Surveillance staff will call back)
Send the report form in an envelope marked "CONFIDENTIAL" to:
HIV Surveillance Unit, Division of Public Health, PO Box 2659, MADISON, WI 53701–2659

If you have any questions, call 608-267-5287 or email DHSHIVSurveillance@dhs.wisconsin.gov.

Confirmed and suspect cases of HIV, including Stage 3 (AIDS), are required to be reported to the Division of Public Health within 72 hours of identification 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.