

			Local Report Number:

MODIFIED BY NMCPHC - Adult HIV Confidential Case Report Form

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name		*	
Did this report initiate a new case investigation? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
Date Patient Interviewed ___/___/_____	*Person Completing Form		*Phone () _____

Patient Demographics (record all dates as mm/dd/yyyy)

Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			
Age in years __		Service: USN / USMC / Other: _____ Active / Reserve / Guard	
Male partners last 12 months: _____	Female Partners last 12 months: _____	Transgender Partners last 12 months: _____	
Current Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male-to-Female (MTF) <input type="checkbox"/> Transgender Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Additional gender identity (specify) _____			
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown		*Month/year patient tested positive: ___/___	
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		_____	

Residence at Diagnosis (add additional addresses in Comments)

*Patient's State of residence when tested positive:			
			*

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No. _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/ coagulation disorder	Specify clotting factor: Date received (mm/dd/yyyy): ___/___/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/____ Last date received ___/___/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____	
Other documented risk (please include detail in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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