COMMONWEALTH of VIRGINIA

Department of Health

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STATE HEALTH COMMISSIONER

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March 13, 2009

Department of the Navy
Navy Medical Center
620 John Paul Jones Circle
Portsmouth, Virginia 23708-2197

ATTN: Lieutenant U.J. Perez
Medical Service Corps, U.S. Navy
Head, Preventative Medicine Department

Dear Lieutenant Perez:

SUBJECT: HIV/AIDS CONFIDENTAL, CASE REPORTS

My name is Anita Johnston and I am the Eastern HIV/AIDS Epidemiology Consultant for the Virginia Department of Health, Division of Disease Prevention. I am writing to introduce myself and to inform you of the changes that have occurred within the Division as it relates to HIV/AIDS case reporting. Our records indicate that your medical center provides care for HIV/AIDS patients. Over the past several years your department has provided us with Adult HIV/AIDS Confidential Case reports and field records for individuals who have been tested and counseled in your facility. Your cooperation and assistance with reporting these cases is greatly appreciated.

Recently, the Virginia Surveillance Program (VSP) has experienced a few changes in how we capture and report information to the Centers for Disease Control (CDC). As mandated by the CDC, VSP implemented a new reporting system, eHARS, in October 2007. This database allows VSP to capture additional information on HIV/AIDS patients and thus better track the progression of the disease.

The CDC will no longer provide CDC 50.52A Adult Case Report forms (ACRF). However, they have provided us with a template for a new ACRF that closely resembles the new database. I have enclosed a copy of the new form with pre-filled sections for your convenience. Please review and feel free to make copies.

In order for a person to be counted as a HIV or AIDS case, the CDC requires specific information be completed on the ACRF. I am enclosing copies of some of the forms that were sent to us with incomplete or unclear information. Please review these documents, complete them and resend them at your earliest convenience. In order for VSP to make a case, the following required information must be completed on the ACRF:

1. **Name** (First and Last)
2. **Date of Birth**
3. **Race** *(Race can only be "Unknown" if the ethnicity is Hispanic)*
4. **Sex at Birth**
5. **Residence of diagnosis zip code** *(*Please note: City and State alone are not valid. A zip code is required. If the client is out of the country, the permanent address information is acceptable)*
6. **Diagnostic status** (HIV or AIDS)
7. **Date of First Confirmatory Test**
8. **Type of Test** *(*Please note: Only Western Blots and **DETECTABLE** viral loads are considered confirmation of disease by the CDC. CD4 counts and EIA's can not be used to verify disease. A doctor's diagnosis with date is acceptable with the accompanying laboratory tests.)*

Thank you for your continued support of the Virginia Surveillance Program. I look forward to working with you in the future. Please feel free to call me at 804-864-8025 or email me at anita.johnston@vdh.virgnia.gov if you have any questions or require additional information.

Sincerely,

Anita Johnston
HIV Surveillance Epidemiology Consultant
804-864-8025

/agc
Enclosure

Required Fields

Adult HIV/AIDS Confidential Case Report

(For patients ≥ 13 years of age at time of diagnosis) ***Return completed form to state/local health department***

_____ Date received at Health Department (enter all dates in mm/dd/yyyy format)

I. Patient Name (first name, middle name/initial, last name) and Address

Patient's Name	Alias	Phone No.

Address	City	County	State	ZIP Code

_____ Date form completed | Document source Other Clinic or source code: A 07 25

II. Health Department Use Only

Soundex Code	Did this report initiate a new case investigation?	Reporting Health Department	State Patient Number
	☑ Yes ☐ No	State	
Surveillance Method		City/County	Social Security Number
A F P R U	Report Medium: Field Visit Mailed Faxed Phone E. Transfer Diskette		

ID Type:	ID Number:
ID Type	ID Number:

III. Demographic Information

Diagnostic Status at Report	Age at Diagnosis	Date of Birth	Alias Date of Birth	Sex at Birth	Country of Birth
☐ HIV infection (not AIDS)	Years (HIV)	Month Day Year	Month Day Year	☐ Male ☐ Female ☐ Unknown	☐ U.S. ☐ Other
☐ AIDS	Years (AIDS)				Specify, If Other:

Gender				Vital Status	Date of Death			State/Territory of Death
☐ Male ☐ Intersexed	☐ Female ☐ Cross Dresser	☐ Female to Male ☐ Drag Queen	☐ Male to Female	☐ Alive ☐ Dead ☐ Unknown	Month	Day	Year	

Ethnicity	Race	
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian ☐ White ☐ Unknown

Residence at Diagnosis-900	☐ Same address as patient address			
Address:	City	County	State/Country	ZIP Code
Residence at Diagnosis-950	☐ Same address as patient address			
Address	City	County	State/Country	Zip Code

IV. Facility of Diagnosis

☐ 900 Diagnosis	☐ 950 Diagnosis	1) Facility Name (900 diagnosis)	2) Facility Name (950 diagnosis)
		Naval - Ports	

1) HIV Facility Address	City	County	State/Country	ZIP Code
	Portsmouth		VA	
2) AIDS Facility Address	City	County	State/Country	Zip Code

900 Facility Setting	Specify Setting If Federal	950 Facility Setting	Specify Setting If Federal	900 Facility Type	Specify Setting Type	950 Facility Type	Specify Setting Type	900 HRSA Funding	950
☐ Public ☑ Federal ☐ State ☐ County ☐ City ☐ Private		☐ Public ☐ Federal ☐ State ☐ County ☐ City ☐ Private		☐ Inpatient Facility ☑ Outpatient Facility ☐ Emergency Room ☐ Screening, Diagnostic, Referral Agency ☐ Laboratory ☐ Other ☐ Unknown	Other	☐ Inpatient Facility ☐ Outpatient Facility ☐ Emergency Room ☐ Screening, Diagnostic, Referral Agency ☐ Laboratory ☐ Other ☐ Unknown		☐ None ☐ Title I ☐ Title II ☐ Title IIII ☐ Title IV ☐ SPNS ☐ Other ☐ Unknown	☐ None ☐ Title I ☐ Title II ☐ Title IIII ☐ Title IV ☐ SPNS ☐ Other ☐ Unknown

Provider Name	Provider Phone No.
Person Completing Form	Phone Number

V. 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:			
o Intravenous/injection drug user			
o Bisexual male			
o Person with hemophilia/coagulation disorder			
o Transfusion recipient with documented HIV infection (consider documenting reason in the Comments section)			
o Transplant recipient with documented HIV infection (consider documenting reason in the Comments section)			
o Person with AIDS or documented HIV infection, risk not specified			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)			
First date received Last date received			
• Received transplant of tissue/organs or artificial insemination			
• Worked in a healthcare 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)			

VI. Laboratory Data

HIV Antibody Tests at Diagnosis (indicate first test—mm/dd/yyyy date)			Record additional HIV antibody tests			Collection Date (mm/dd/yyyy)
HIV-1 IFA	☐ Positive	☐ Negative	HIV-1 IFA	☐ Positive	☐ Negative	
HIV-1 Western Blot	☐ Positive	☐ Negative	HIV-1 Western Blot	☐ Positive	☐ Negative	
Rapid	☐ Positive	☐ Negative	Rapid	☐ Positive	☐ Negative	
HIV-1 EIA	☐ Positive	☐ Negative	HIV-1 EIA	☐ Positive	☐ Negative	
HIV-1/2 EIA	☐ Positive	☐ Negative	HIV-1/2 EIA	☐ Positive	☐ Negative	
HIV-2 EIA	☐ Positive	☐ Negative	HIV-2 EIA	☐ Positive	☐ Negative	
HIV-2 Western Blot	☐ Positive	☐ Negative	HIV-2 Western Blot	☐ Positive	☐ Negative	

HIV Detection Tests (record all tests—mm/dd/yyyy date)					
HIV-1 P24 Antigen	☐ Pos	☐ Neg	HIV-1 P24 Antigen	☐ Pos	☐ Neg
HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg	HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg
HIV-1 Culture	☐ Pos	☐ Neg	HIV-1 Culture	☐ Pos	☐ Neg
HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg	HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg
HIV-2 Culture	☐ Pos	☐ Neg	HIV-2 Culture	☐ Pos	☐ Neg

Immunologic Lab Tests (record additional CD4 tests on VA Lab Reporting Form)				Collection Date (mm/dd/yyyy)
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 most recent test; record additional viral load tests on VA Lab Reporting Form)

	Copies/μL	Log	Collection Date (mm/dd/yyyy)
HIV-1 RNA NASBA			
HIV-1 RNA RT-PCR	Viral load		
HIV-1 RNA bDNA	(also acceptable)		
HIV-1 RNA Other			

Date of last documented negative HIV test when available Specify type of test:

Is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown

If **YES**, enter date of diagnosis (mm/dd/yyyy):

VII. Clinical Status

Clinical Record Reviewed	Enter date patient was diagnosed as:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy) mm/dd/yyyy	Symptomatic (not AIDS) mm/dd/yyyy
□ Yes □ No			

AIDS Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy	AIDS Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date 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:	□ Yes □ No □ Unknown

VIII. Treatment/Services Referrals

Has this patient been informed of his/her HIV 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 □ Unknown	This patient received or is receiving:	Antiretroviral therapy	□ Yes □ No □ Unknown
	Substance abuse treatment services	□ Yes □ No □ Not Applicable □ Unknown		PCP prophylaxis	□ Yes □ No □ Unknown
This patient has been enrolled at (clinical trial):	□ NIH Sponsored □ Other	□ None □ Unknown	This patient has been enrolled at (clinic):	□ HRSA Sponsored □ Other	□ None □ 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:	□ Yes	□ No	□ Unknown
Is this patient currently pregnant?	□ Yes	□ No	□ Unknown
Has this patient delivered live-born infants?	□ Yes	□ No	□ 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 StateNo
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			

IX. Additional Laboratory Data

HIV Antibody				Viral Load Tests		
HIV-1 IFA	☐ Positive	☐ Negative	**Collection Date**		Copies/µL	**Collection Date** (mm/dd/yyyy)
HIV-1 Western Blot	☐ Positive	☐ Negative		HIV-1 RNA NASBA		
Rapid	☐ Positive	☐ Negative		HIV-1 RNA PCR		
HIV-1 EIA	☐ Positive	☐ Negative		HIV-1 RNA bDNA		
HIV-1/2 EIA	☐ Positive	☐ Negative		HIV-1 RNA Other		
HIV-2 EIA	☐ Positive	☐ Negative		Other		
HIV-2 Western Blot	☐ Positive	☐ Negative		Other		

HIV Detection Tests			Collection Date	Immunologic Lab Tests	Copies		Collection Date (mm/dd/yyyy)
HIV-1 P24 Antigen	☐ Pos	☐ Neg		CD4 count		cells/µl	
HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg		CD4 percent		%	
HIV-1 Culture	☐ Pos	☐ Neg		CD4 count		cells/µl	
HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg		CD4 percent		%	
HIV-2 Culture	☐ Pos	☐ Neg					

X. eHARS Local Fields

HIV LOCAL USE FIELDS		AIDS LOCAL USE FIELDS	
prm: HEALTH DEPT. (Public) PRIVATE (MILITARY)		HEALTH DEPT. (Public) PRIVATE MILITARY	
code (status of HIV case)			
hdate (Date Entered/Stat Analyst Initials)		adate (Date Entered/Stat Analyst Initials)	
hdist (District)		adist (District)	
hreg (Region)	Eastern	areg (Region)	
hmsa (Metropolitan Statistical Area)	Norfolk	amsa (Metropolitan Statistical Area)	
hinterv (Interview Code)	Military	ainterv (Interview Code)	
hcare (Care Provider)	Naval-POMS	acare (Care Provider)	
modeva (Local Mode of Exposure)		modeva (Local Mode of Exposure)	
hphys (Physician from Standard List)		phys (Physician from Standard List)	

X. COMMENTS