



**VII. PHYSICIAN INFORMATION**

Physician's Name: \_\_\_\_\_ (Last, First, M.I.) Phone No.: ( ) \_\_\_\_\_ Medical Record No. \_\_\_\_\_  
 Hospital/Facility: \_\_\_\_\_ Person \_\_\_\_\_ Completing Form: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
**- Physician identifier information is not transmitted to CDC! -**

**VIII. Viral Load Data\***

bDNA _____	NASBA _____	RNA PCR _____	Results _____	Date _____
bDNA _____	NASBA _____	RNA PCR _____	Results _____	Date _____
bDNA _____	NASBA _____	RNA PCR _____	Results _____	Date _____

\*Viral loads are measured by several types of tests. A unit of measurement reported may be copies/ml or Keq/ml. bDNA (branched CAN), NASBA (Nucleic acid sequencer base amplification), RNA PCR (Quantitative PCR)

**IX. CLINICAL STATUS**

CLINICAL RECORD REVIEWED:	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 0	ENTER DATE PATIENT WAS DIAGNOSED AS:	<b>ASYMPTOMATIC</b> (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Mo. <input type="checkbox"/>	Yr. <input type="checkbox"/>	Symptomatic (not AIDS):	Mo. <input type="checkbox"/>	Yr. <input type="checkbox"/>
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AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date		AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date	
	Def.	Pres.	Mo.	Yr.		Def.	Pres.	Mo.	Yr.
Candidiasis, bronchi, trachea, or lungs .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent term)	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, immunoblastic .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>
Carcinoma, invasive cervical .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	(or equivalent term)				
Coccidioidomycosis, disseminated .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, primary in brain .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>
or extrapulmonary					<i>Mycobacterium avium</i> complex .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	or <i>M. kansasii</i> , disseminated or extrapulmonary				
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis, pulmonary</i> * .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis, disseminated</i> or extrapulmonary*	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision) ..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycobacterium, of other species or</i> .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	unidentified species, disseminated or extrapulmonary				
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>Pneumocystis carinii</i> pneumonia .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis, disseminated or extra pulmonary	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	<i>Pneumonia, recurrent, in 12 mo. period</i> ..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal (> 1 mo. duration)	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>	Progressive multifocal leukoencephalopathy	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>	Salmonella septicemia, recurrent .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>
					Toxoplasmosis of brain .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>	<input type="checkbox"/>
					Wasting syndrome due to HIV .....	<input type="checkbox"/> 1	NA	<input type="checkbox"/>	<input type="checkbox"/>

Def. = definitive diagnosis      Pres. = presumptive diagnosis      \*RVCT CASE NO.:

• If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?  1 Yes     0 No     9 Unknown

**X. TREATMENT/SERVICES REFERRALS**

Has this patient been informed of his/her HIV infection? .....	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 9 Unk.	This patient is receiving or has been referred for:	Yes	No	NA	Unk.
This patient's partners will be notified about their HIV exposure and counseled by:				▪ HIV-related medical services .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	-	<input type="checkbox"/> 9
<input type="checkbox"/> 1 Health department <input type="checkbox"/> 2 Physician/provider <input type="checkbox"/> 3 Patient <input type="checkbox"/> 9 Unk.				▪ Substance abuse treatment services .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9
				▪ Mental health services .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 8	<input type="checkbox"/> 9
				Specify: _____				

This patient received or is receiving:	This patient has been enrolled at:	This patient's medical treatment is primarily reimbursed by:
▪ Anti-retroviral therapy .....	<u>Clinical Trial</u>	<input type="checkbox"/> 1 Medicaid
Yes <input type="checkbox"/> 1    No <input type="checkbox"/> 0    Unk. <input type="checkbox"/> 9	<input type="checkbox"/> 1 NIH-sponsored	<input type="checkbox"/> 2 Private insurance/HMO
▪ PCP prophylaxis ...	<u>Clinic</u>	<input type="checkbox"/> 3 No coverage
Yes <input type="checkbox"/> 1    No <input type="checkbox"/> 0    Unk. <input type="checkbox"/> 9	<input type="checkbox"/> 2 Other	<input type="checkbox"/> 4 Other Public Funding
	<input type="checkbox"/> 3 None	<input type="checkbox"/> 7 Clinical trial/ government program
	<input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 9 Unknown

**XI. Post-Test Counseling**

Has the patient been told not to donate blood, plasma, organs, or other body tissue?  1 Yes  0 No  9 Unk Date \_\_\_\_\_

Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior?  1 Yes  0 No  9 Unk Date \_\_\_\_\_

Name of person that provided post-test counseling \_\_\_\_\_ Telephone No.: ( ) \_\_\_\_\_

**XII. For Females Only**

Is the patient currently pregnant? .....  1 Yes  0 No  9 Unknown  
Due Date: \_\_\_\_\_

Obstetrician/NP/Clinic/Family Doctor: \_\_\_\_\_ Telephone No.: ( ) \_\_\_\_\_

Is the above provider aware of her HIV status? .....  1 Yes  0 No  9 Unknown

Has this patient been offered information regarding the use of drugs during pregnancy? .....  1 Yes  0 No  9 Unknown  
 Information offered and patient declined

**Previous Pregnancies since 1992**

# of Abortions: \_\_\_\_\_ Dates \_\_\_\_\_

# of Miscarriages: \_\_\_\_\_ Dates \_\_\_\_\_

# of Stillbirths \_\_\_\_\_ Dates \_\_\_\_\_

**Live Births**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**State Use Only**

Child's State Patient No. \_\_\_\_\_ Child's State Patient No. \_\_\_\_\_

Child's State Patient No. \_\_\_\_\_ Child's State Patient No. \_\_\_\_\_

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