Spokane County HIV/AIDS case reporting may be done confidentially over the phone by calling 509-324-1544

CLINICAL AIDS

Disease	Diagnosis Date (mm/dd/yyyy)	dx method[5] Presumptive	dx method[5] Definitive
Candidiasis, bronchi, trachea, or lungs	___/___/______		☐
Candidiasis, esophageal	___/___/______	☐	☐
Cervical cancer, invasive	___/___/______		☐
Coccidioidomycosis, disseminated or extrapulmonary	___/___/______		☐
Cryptococcosis, extrapulmonary	___/___/______		☐
Cryptosporidiosis, chronic[6] intestinal	___/___/______		☐
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/______		☐
Cytomegalovirus retinitis (with loss of vision)	___/___/______	☐	☐
HIV encephalopathy	___/___/______		☐
Herpes simplex: chronic[6] ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/______		☐
Histoplasmosis, diss. or extrapulmonary	___/___/______		☐
Isosporiasis, chronic[6] intestinal	___/___/______		☐
Kaposi's sarcoma	___/___/______	☐	☐
Lymphoma, Burkitt's (or equivalent)	___/___/______		☐
Lymphoma, immunoblastic (or equivalent)	___/___/______		☐
Lymphoma, primary in brain	___/___/______		☐
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/______	☐	☐
M. tuberculosis, pulmonary	___/___/______	☐	☐
M. tuberculosis, diss. or extrapulmonary	___/___/______	☐	☐
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/______	☐	☐
Pneumocystis pneumonia	___/___/______	☐	☐
Pneumonia, recurrent[7]	___/___/______	☐	☐
Progressive multifocal leukoencephalopathy	___/___/______		☐
Salmonella septicemia, recurrent	___/___/______		☐
Toxoplasmosis of brain	___/___/______	☐	☐
Wasting syndrome due to HIV[8]	___/___/______		☐

Call or Return completed form to:

Spokane Regional Health District
1101 West College Ave
Suite 372
Spokane, WA 99201
(509) 324-1544

FOOTNOTES

[1]Patient identifier information is not sent to CDC.

[2]Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.
Inpatient dx: diagnosed during a hospital admission of at least one night.

[3]After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.

[4]If case progresses to AIDS, please notify health department.

[5]If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.

[6]Chronic: more than one month's duration.

[7]Recurrent: 2 or more episodes within a 1-year period.

[8]Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code

FUI Assigned:

☐ Complete ☐ Incomplete ☐ OOS

RVCT Number:

WASHINGTON STATE REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

ASSURANCES OF CONFIDENTIALITY AND EXCHANGE OF MEDICAL INFORMATION

- Several Washington State laws pertain to HIV/AIDS reporting requirements. These include: Maintain individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protect patient identifying information, meet published standards for security and confidentiality if retaining names of those with asymptomatic HIV, (WAC 246-101-230,520,635); investigate potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclose HIV/AIDS identifying information (WAC 246-101-120,230,520,635 and RCW 70.24.105).
- Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).
- Anyone who violates Washington State confidentiality laws may be fined a maximum of $10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

FOR PARTNER NOTIFICATION INFORMATION

- Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).
- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call HIV/AIDS Prevention & Education Services, DOH, at (360) 236-3422, or your local health department. In King County, please call Edith Allen, Public Health Seattle & King County, at (206) 744-4377.

Comments:

Date LHJ received the report indicative of a new HIV infection:

☐☐ / ☐☐ / ☐☐☐☐

Month / Day / Year

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Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #: ( ) -

Social Security #: - -

Current Street Address:

City:

Zip Code:

[1] Alive
[2] Dead

Birthdate (mm/dd/yyyy) / /

Death Date (mm/dd/yyyy) / /

State of Death:

Sex at birth:
[1] Male
[2] Female

Gender or identity change:
[1] Male to Female
[2] Female to Male

Ethnicity:
[1] Hispanic
[2] Not Hispanic

Race (check all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ American Indian/Alaska Native

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Never married
- ☐ Unknown

Country of birth: ☐ U.S. ☐ Other: ____________________

If other, length of residence in US: ____________________

Was patient dx in another state? [1] Yes [2] No
If yes, specify state:

Residence at time of diagnosis if different than current address:
City: County: Zip Code:

Med. Record #/Patient Code:

Name & City of facility of diagnosis:

[1] Outpatient dx[2] [2] Inpatient dx[2]

PROVIDER INFORMATION

Physician: Phone: City:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977[3]

Check all that apply	Yes	No	Unk
Sex with male	☐	☐	☐
Sex with female	☐	☐	☐
Injection drug use	☐	☐	☐
Received clotting factors for hemophilia	☐	☐	☐
Transfusion, Transplant, or Insemination	☐	☐	☐
Heterosexual relations with:			
Injection drug user	☐	☐	☐
Bisexual man	☐	☐	☐
Person with hemophilia	☐	☐	☐
PWA/HIV transfusion or transplant	☐	☐	☐
PWA/HIV risk not specified	☐	☐	☐
Worked in health-care or laboratory setting	☐	☐	☐

If yes, occupation: ________________

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

LABORATORY DATA[4]

Last documented negative test Test Date (mm/dd/yyyy) ___/___/____ Type of test:

EARLIEST POSITIVE HIV ANTIBODY TESTS:

Type of Test:	Test Date (mm/dd/yyyy)	
HIV-1 EIA	___/___/____	☐ Test not done
HIV-1 Western Blot or IFA	___/___/____	☐ Test not done

HIV VIRAL LOAD TESTS:

Type of Test:	Test Date (mm/dd/yyyy)	
Earliest HIV Viral Load	____/____/_______	☐ Copies per mL ____________ ☐ Undetectable
Most recent HIV Viral Load	____/____/_______	☐ Copies per mL ____________ ☐ Undetectable

OTHER HIV TESTS

Type of test: Rapid, Culture, HIV-2, Combined Ab/Ag________________

Date (mm/dd/yyyy): ___/___/______ Result:

PHYSICIAN DIAGNOSIS OF INFECTION:

No laboratory tests are available but Physician documents HIV infection Date (mm/dd/yyyy): ___/___/____

EARLIEST DRUG RESISTANCE TEST

Date (mm/dd/yyyy): ___/___/____ ☐ Test not done

Type: Genotype Phenotype

Laboratory: ________________________________

CD4 LEVELS

Type of Test:	Test Date (mm/dd/yyyy)	Count	Percent
Earliest CD4	___/___/______	_________cells/µl	______%
Most Recent CD4	___/___/______	_________cells/µl	______%
First CD4 <200 µl or < 14%	___/___/______	_________ cells/µl	______%

TREATMENT / SERVICES REFERRALS

	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	☐	☐	☐	
This patient is receiving/has been referred for:	☐	☐	☐	
• HIV related medical service				
• HIV Social Service Case Management	☐	☐	☐	
• Substance abuse treatment services	☐	☐	☐	☐
This patient received/ is receiving: • Antiretroviral (ARV) therapy	☐	☐	☐	
If yes, earliest date started ARV after diagnosis (mm/dd/yyyy): ____/____/____				
• PCP prophylaxis	☐	☐	☐	

FOR WOMEN

Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unk

Expected delivery date (mm/dd/yyyy) _______/_______/_______

HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno: ________________

Date: _____ / _____ /_________ Source: ______________

☐ New Case ☐ Progression ☐ Update, no status change

Note AIDS indicator diseases on reverse

☐ CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES
If checked, skip Clinical AIDS section on reverse.

HIV TESTING HISTORY

Complete this section if new diagnosis or new patient OR attach completed questionnaire ☐ ***Not applicable***

Date patient reported info (mm/dd/yyyy): ____/____/______

Information from: ☐ patient interview ☐ review of medical record ☐ provider report ☐ PEMS ☐ other

FIRST SELF-REPORTED POSITIVE HIV TEST

Ever had a previous positive test? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Date of first positive test (mm/yyyy): _______/__________

LAST SELF-REPORTED NEGATIVE HIV TEST

Ever had a negative test? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Date of last negative test (mm/yyyy): ______/__________

OTHER HIV TESTS

Number of negative HIV tests in 24 months before first positive test: ______

☐ Refused ☐ Unknown

ANTIRETROVIRAL (ARV) USE (including prophylaxis)

	Yes	No	Unk
Ever taken any ARV:	☐	☐	☐

If yes: Names of medications used: ______________________________

Date first began (mm/dd/yyyy): ____/____/______

Date of last use (mm/dd/yyyy): ____/____/______

DRUG USE

Methamphetamine use? ☐ Yes ☐ No ☐ Unk

If, yes: ☐ Injection ☐ Non-injection, specify: ______________ ☐ Unk

PARTNER SERVICES NOTES

[1, 2, 3, 4] Footnotes on reverse