

HIV Surveillance Program

Bureau of HIV/STI/Viral Hepatitis



Department of
Health

OHIO ADULT HIV CASE REPORT FORM

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

PATIENT IDENTIFICATION

First Name:	Middle Name:	Last Name:	Alias:
Address Type: <input type="checkbox"/> Residential <input type="checkbox"/> Jail (City or County) <input type="checkbox"/> Unhoused <input type="checkbox"/> Prison (State or Federal) <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Other		Street Address:	
City:	County:	State / Country:	ZIP:
Phone:	Social Security # (Last Four):	Medical Record Number:	

PATIENT DEMOGRAPHICS

Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Vital Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead	Date of Death:
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other - Specify:		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	
Race (Check all that apply): <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Black / African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> White <input type="checkbox"/> Unknown			

PREVIOUS POSITIVE INFORMATION (Only fill out if patient has previously tested positive for HIV)

Diagnosis Date:	State / Country of Diagnosis:	Diagnosing Facility:
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LABORATORY DATA

Ordering Provider:	Ordering Facility:	Performing Laboratory:
HIV Screening Test at Diagnosis:		CD4 Tests:
HIV-1/2 Screening: <input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> IND	Collection Date:	Count: Percent: % Collection Date:
Point-of-Care Rapid HIV Test: <input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> IND	Collection Date:	Resistance Tests:
		Genotype Test Done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Collection Date:
HIV Confirmation / Differentiation (Geenius):		Other HIV Testing (Enter Any Additional HIV Tests):
HIV-1: <input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> IND	Collection Date:	Test Type: Result: Collection Date:
HIV-2: <input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> IND	Collection Date:	
HIV Viral Load Test - Quantitative (D = Detected, ND = Not Detected):		
HIV-1 RNA/DNA NAAT: <input type="checkbox"/> D <input type="checkbox"/> ND	Copies/ml: Collection Date:	
HIV Detection Tests - Qualitative (D = Detected, ND = Not Detected):		Past HIV Testing
HIV-1 RNA/DNA NAAT: <input type="checkbox"/> D <input type="checkbox"/> ND	Collection Date:	Has this person ever had a negative HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HIV-2 RNA/DNA NAAT: <input type="checkbox"/> D <input type="checkbox"/> ND	Collection Date:	If YES, date of the most recent negative test:

PATIENT HISTORY

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 nonprescription drugs or shared injection equipment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Heterosexual contact with a person who injects drugs.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Heterosexual contact with bisexual male (for patient assigned female at birth only).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Heterosexual contact with person living with HIV.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other-specify:	

OPPORTUNISTIC INFECTIONS (Click here for common opportunistic infections)			
Diagnosis(es) - list all that apply:			Diagnosis Date:
TREATMENT HISTORY			
Has patient ever taken any antiretroviral medications (ARVs): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If YES, date ARV's last taken:
ARV's currently taking (list all that apply):			
FOR PREGNANT PATIENT OF CHILDBEARING POTENTIAL			
Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If currently pregnant, estimated date of delivery:		Has the patient been referred for prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Patient delivered live-born infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If delivered, most recent delivery date:		Child's Name:
Delivery Hospital:		City:	State:
FACILITY PROVIDING INFORMATION			
Facility Name:		Street Address:	
City:	County:	State:	Zip Code:
Name of Provider that Ordered HIV Diagnostic Tests:		Specialty:	Phone Number:
PERSON PROVIDING INFORMATION			
Date Form Completed:	Person Completing Form:		Phone Number/Email:
COMMENTS SECTION			
Provide any additional information about the patient:			

Complete and submit the case form by one of the following methods:

Fax: 614-388-9782

Mail the report form in an envelope marked “Confidential” to:

Ohio Department of Health
HIV Surveillance Program
246 N. High St
Columbus, OH 43215

If you have any questions, email HIVsurveillance@odh.ohio.gov.

All confirmed cases of HIV, including Stage 3 (AIDS), are required to be reported by healthcare providers and laboratories to the designated health authorities per Ohio Administrative Code 3701-3-12.