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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES (DHS)**  Division of Public Health  F-44338 (12/2023) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **STATE OF WISCONSIN**  Wis. Stat. § 252.05 requires that  this information be reported. | | | | | | | | | | | | | | | |
| **WISCONSIN HIV CASE REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Patients >13 Years of Age at Time of Diagnosis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | Diagnosis Status: Acute  HIV  Stage 3 (AIDS) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DHS State Number | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (DHS use only) | | | | | |
| **PATIENT IDENTIFICATION** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Legal Name | | | | | | | First Name | | | | | | | | | | | | | | | | | | | | | | | Middle Name | | | | | | | | | | | | | | Last Name | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
| Also Known As (e.g., alias, married, maiden) | | | | | | | First Name | | | | | | | | | | | | | | | | | | | | | | | Middle Name | | | | | | | | | | | | | | Last Name | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
| Address Type | | | | | | Residential  Correctional Facility  Military Base | | | | | | | | | | | | | | | | | | | | | Foster Home  Homeless  Postal | | | | | | | | | | | | | | Shelter  Temporary  Other | | | | | | | | | | | |
| Current Street Address | | | | | | | | | | | | | | | | | | | | | | | | If current address is a facility (e.g., corrections, nursing home, shelter), provide name | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | | | | | | County | | | | | | | | | | | | | | | | | | | | State/Country | | | | | | | | | | | | | | | | | Zip Code |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  |
| Phone – Primary | | | | | | | | | | | | | | | Phone – Secondary | | | | | | | | | | | | | | | | | | | | Social Security Number\* | | | | | | | | | | | Vital Status | | | | | | Date of Death |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Alive  Dead | | | | | |  |
| **PATIENT DEMOGRAPHICS** (Record all dates as mm/dd/yyyy.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth | | | | | | | | | | | | Country of Birth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Preferred Language | | | | | | | | |
|  | | | | | | | | | | | | US  Other – specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Sex Assigned at Birth | | | | | | | | Current Gender Identity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date Identified: | | | |
| Male  Female  Unknown | | | | | | | | Cisgender Man | | | | | | | | | | | | | | | Transgender Man | | | | | | | | | | | | | | | | Unknown | | | | | | | | | | | | | |
| Cisgender Woman | | | | | | | | | | | | | | | Transgender Woman | | | | | | | | | | | | | | | | Additional Gender Identity – specify: | | | | | | | | | | | | | |
| **Ethnicity** | | Hispanic/Latino  Not Hispanic/Latino  Unknown | | | | | | | | | | | **Race**  (Check all that apply) | | | | | | | | | | | | | | | American Indian/Alaska Native  Black/African American  White | | | | | | | | | | | | | | | | | Asian  Native Hawaiian/Pacific Islander  Unknown | | | | | | | |
| Sexual Orientation | | | | Straight or heterosexual  Lesbian or gay  Bisexual  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional sexual orientation – specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date Identified: | | | |
| **For Person of Childbearing Potential** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This patient is receiving or has been referred for gynecological and/or obstetrical (OBGYN) services:  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | Is this patient currently pregnant? | | | | | | | | | | | | | | | | | | | Has this patient delivered live-born infants? | | | | | | | | | |
| Yes  No  Unknown | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | |
| If currently pregnant, estimated date of delivery: | | | | | | | | | | | | | | | | | | | | | | | | Has this patient been referred for prenatal care?  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | Date of referral:        OBGYN  WI HIV Primary Care Support Network | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENCE AT DIAGNOSIS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address at HIV Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | County | | | | | | | | State/Country | | | | | | | Zip Code | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | |
| **Check if** **same as current address** | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address at Stage 3 (AIDS) Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | County | | | | | | | | State/Country | | | | | | | Zip Code | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | |
| **Check if same as current address** | | | | | | | | | | | | | | | | | | | | | | | |
| **FACILITY OF DIAGNOSIS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Street Address | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | | | | | | | | | | | | | | | County | | | | | | | | | | | | State/Country | | | | | | | | | | | | | | | Zip Code | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |
| Facility  Type | | | Inpatient  Hospital  Other (specify) | | | | | | | | | | | | | | | Outpatient | | | | | | | | | | | | | | | | | | Other Facility | | | | | | | | | | | | | | |  | |
| Private Physician’s Office  Adult HIV Clinic  VAMC  Other – specify: | | | | | | | | | | | | | | | | | | HIV Testing Site  STD Clinic  Blood/Plasma Center  Family Planning Clinic | | | | | | | | | | | | | **A#**  Emergency Room  Corrections  Other – specify: | | | |
| Name of Provider That Ordered HIV Diagnostic Tests | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Specialty | | | | | | | | | | | | | | | Phone | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |
| **FACILITY PROVIDING INFORMATION  Check if SAME as Facility of Diagnosis and go to Person Providing Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Street Address | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | | | County | | | | | | | | | | | | | | | | | | | State/Country | | | | | | | | | | | | | | | | | | | | Zip Code | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | |
| Facility  Type | | | Inpatient  Hospital  Other – specify | | | | | | | | | | | | | | | Outpatient | | | | | | | | | | | | | | | | | | Other Facility | | | | | | | | | | | | | | | | | |
| Private Physician’s Office  Adult HIV Clinic  VAMC  Other – specify | | | | | | | | | | | | | | | | | | | | HIV Testing Site  STD Clinic  Blood/Plasma Center  Family Planning Clinic | | | | | | | | | | **A#**  Emergency Room  Corrections  Other – specify | | | | | |
| **PERSON PROVIDING INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date Form Completed (mm/dd/yyyy) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Person Completing Form | | | | | | | | | | | | | | | | | | | | Phone | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | |
| **PATIENT HISTORY** (Check all that apply. Record additional risk information in Comments Section.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This patient had: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sex with person assigned male at birth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Sex with person assigned female at birth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Injected nonprescription drugs or shared injection equipment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Heterosexual contact with person who injects drugs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Heterosexual contact with bisexual person assigned male at birth (for patient assigned female at birth only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Heterosexual contact with person living with HIV, risk not specified | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Received transplant/transfusion/clotting disorder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Worked in a healthcare or clinical laboratory setting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| Perinatally acquired HIV | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | |
| **OPPORTUNISTIC DIAGNOSES** (Record additional diagnoses in Comments Section. [**Click here**](https://www.cdc.gov/hiv/basics/livingwithhiv/opportunisticinfections.html) for common opportunistic diagnoses.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Diagnosis Date (mm/dd/yyyy) | | | | | | | | |
| Candidiasis, esophageal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Kaposi’s sarcoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Pneumocystis pneumonia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Wasting syndrome due to HIV | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| **LABORATORY DATA** (Record dates as mm/dd/yyyy and additional tests and POC rapid HIV test types in Comments Section.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HIV Screening Test at Diagnosis**  **(Non-Differentiating/Differentiating)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | **Immunologic Tests (CD4)** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | Pos | | | | Neg | | | | | Ind | | | | | Collection Date | | | | | |  | | | First CD4 <200 µL or <14%: | | | | | | | | | | | | | | | | | | Collection Date | |
| HIV-1 EIA | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | Count | | | | | |  | | | | | Percent | | | | | % | |  | |
| HIV-1/2 EIA | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | Most Recent CD4: | | | | | | | | | | | | | | | | | | | |
| HIV-1/2 Ag/Ab | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | Count | | | | | |  | | | | | Percent | | | | | % | |  | |
| HIV-1 WB/IFA | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | **Resistance Tests** | | | | | | | | | | | | | | | | | | | |
| HIV-2 EIA | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | |  | | | | | | | | | | | | | | | | | | Collection Date | |
| HIV-2 WB | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | Genotyping  Yes  No  Unknown | | | | | | | | | | | | | | | | | |  | |
| Point-of-Care Rapid HIV Test 1 | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | **Past HIV Testing** | | | | | | | | | | | | | | | | | | | |
| Point-of-Care Rapid HIV Test 2 | | | | | | | | | | |  | | | |  | | | | |  | | | | |  | | | | | |  | | | Has this person ever had a negative HIV test? | | | | | | | | | | | | | | | | | | | |
| **HIV Antibody Test at Diagnosis (Differentiating/Supplemental)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes, medical record Date of test:       Test type: | | | | | | | | | | | | | | | | | | | |
|  | | | | | Pos | | | | Neg | | | | | | | Ind | | | | | Collection Date | | | | | | | | | |  | | | Yes, self-report Date of test:       Test type: | | | | | | | | | | | | | | | | | | | |
| HIV-1 | | | | |  | | | |  | | | | | | |  | | | | |  | | | | | | | | | |  | | | No | | | | | | | | | | | | | | | | | | | |
| HIV-2 | | | | |  | | | |  | | | | | | |  | | | | |  | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | |
| **HIV Detection/Viral Load Tests (Quantitative)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Has this patient ever had a positive HIV test? | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | Copies/ml | | | | | | | | Collection Date | | | | | | | | |  | | | Yes, medical record Date of test:       Test type: | | | | | | | | | | | | | | | | | | | |
| First HIV-1 RNA/DNA NAAT | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | Yes, self-report Date of test:       Test type: | | | | | | | | | | | | | | | | | | | |
| Most recent HIV-1 RNA/DNA NAAT | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | No | | | | | | | | | | | | | | | | | | | |
| HIV-2 RNA NAAT | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | |
| **HIV Detection Tests (Qualitative)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Collection Date | |
| HIV-1 RNA/DNA NAAT (Nucleic Acid Amplification Test) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Detectable  Undetectable | | | | | | | | | | | | | | | | | | |  | |
| HIV-2 RNA NAAT (Nucleic Acid Amplification Test) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Detectable  Undetectable | | | | | | | | | | | | | | | | | | |  | |
| HIV 1-2 Dual NAAT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | HIV-1  HIV-2  Both  Undetectable | | | | | | | | | | | | | | | | | | |  | |
| **TREATMENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has patient ever taken any antiretroviral medications (ARVs)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Has this patient been informed of their HIV diagnosis? | | | | | | | | | | | | | | | | | | | | | |
| Yes  No  Unknown Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | |
| Reason for ARV use (select all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | ARVs ever taken (select all that apply) [**Click for full ARV list**](https://www.dhs.wisconsin.gov/publications/p02760.pdf) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HIV treatment  Pre-exposure prophylaxis (PrEP)  Post-exposure prophylaxis (PEP)  Other reasons | | | | | | | | | | | | | | | | | | | | | | | | | | Atripla  Biktarvy Cabenuva  Descovy  Genvoya  Juluca  Odefsey  Prezista  Symtuza  Tivicay  Triumeq  Truvada  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the earliest date any ARVs were taken (including prior to diagnosis)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | What is the date of last ARV use? | | | | | | | | | | | |
| **COMMENTS SECTION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Complete and submit the case report form by one of the following (preferred in bold):  If you have any questions, call 608-267-5287 or email [DHSHIVSurveillance@dhs.wisconsin.gov](mailto:DHSHIVsurveillance@dhs.wisconsin.gov).   1. **Submit electronically via** [**Wisconsin Electronic Disease Surveillance System**](https://www.dhs.wisconsin.gov/wiphin/wedss.htm) **(WEDSS)** 2. **Fax to 608-720-3548** 3. **Call 608-267-5287 to leave a message (HIV Surveillance staff will call back)** 4. Send the report form in an envelope marked “CONFIDENTIAL” to:   Scott Stokes, Division of Public Health, PO Box 2659, MADISON, WI 53701–2659 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Confirmed and suspect cases of HIV, including Stage 3 (AIDS), are required to be reported to the Division of Public Health within 72 hours of identification per Wis. Stat. § 252.05. Information provided is confidential as required per Wis. Stat. § 252.15.  \*Disclosure of Social Security Number is voluntary. The Social Security Number and other information on this form are used for surveillance, control, and prevention of HIV infections. The information is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated and will not otherwise be disclosed or released without the consent of the individual. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |