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| **DEPARTMENT OF HEALTH SERVICES (DHS)**Division of Public HealthF-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 |
|       |       |       |       |
| FacilityType | 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 |
|       |       |       |       |
| FacilityType | 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** |
|       |
|  | 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. 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. |