Public Health
IOWA HHS

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Reporting HIV and AIDS in Iowa

WHAT'S REPORTABLE

AIDS has been a reportable disease in Iowa since February 1983. HIV became reportable by name in Iowa on July 1, 1998. **Iowa Administrative Code 641.11.6.**, below, details reporting.

641—11.6(141A) Reporting of diagnoses and HIV-related tests, events, and conditions to the department.

11.6(1) The following constitute reportable events related to HIV infection:

a. A test result indicating HIV infection, including:

(1) Confirmed positive results on any HIV-related test or combination of tests, including antibody tests, antigen tests, cultures, and nucleic acid amplification tests.

(2) A positive result or report of a detectable quantity on any other HIV detection (non-antibody) tests, and results of all viral loads, including nondetectable levels.

b. AIDS and AIDS-related conditions, including all levels of CD4+ T-lymphocyte counts.

c. Birth of an infant to an HIV-infected mother (perinatal exposure) or any (positive, negative, or undetectable) non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger.

d. Death resulting from an AIDS-related condition, or death of a person with HIV infection.

11.6(2) Within seven days of the receipt of a person's confirmed positive test result indicating HIV infection, the director of a plasma center, blood bank, clinical laboratory or public health laboratory that performed the test or that requested the confirmatory test shall make a report to the department on a form provided by the department.

11.6(3) Within seven days of the receipt of a test result indicating HIV infection, which has been confirmed as positive according to prevailing medical technology, or immediately after the initial examination or treatment of a person infected with HIV, the physician or other health care provider at whose request the test was performed or who performed the initial examination or treatment shall make a report to the department on a form provided by the department.

11.6(4) Within seven days of diagnosing a person as having AIDS or an AIDS-related condition, the diagnosing physician shall make a report to the department on a form provided by the department.

11.6(5) Within seven days of the death of a person with HIV infection, the attending physician shall make a report to the department on a form provided by the department.

11.6(6) Within seven days of the birth of an infant to an HIV-infected mother or a receipt of a laboratory result (positive, negative, or undetectable) of a non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger, the attending physician shall make a report to the department on a form provided by the department.

11.6(7) The report shall include:

a. The person's name, address, date of birth, gender, race and ethnicity, marital status, and telephone number.

b. The name, address and telephone number of the plasma center, blood bank, clinical laboratory or public health laboratory that performed or requested the test, if a test was performed.

c. The address of the physician or other health care provider who requested the test.

d. If the person is female, whether the person is pregnant.

11.6(8) All persons who experience a reportable event while receiving services in the state, regardless of state of residence, shall be reported.

Need reporting forms? Want to call in a report? Have questions? Need surveillance data?

Alagie "Al" Jatta, HIV Surveillance Coordinator: 515-322-8819 | alagie.jatta@idph.iowa.gov
Samoane Don, HIV Surveillance Epidemiologist: 515-721-8486 | samoane.don@idph.iowa.gov

For free postpaid "03 CONFIDENTIAL" envelopes, call 515-322-8819

COMPLETED FORMS CAN BE SENT VIA THE U.S. POSTAL SERVICE OR YOU CAN USE THE FORM TO COLLECT THE REQUIRED DATA AND THEN CALL US. FAXING OR EMAILING OF COMPLETED FORMS IS NOT ALLOWED!

By Mail:

Iowa Division of Public Health
321 East 12th Street
Des Moines, IA 50319
"03 Confidential"

By Phone:

Al Jatta at 515-322-8819 or Samoane Don at 515-721-8486

INSTRUCTIONS

Don't panic. The form can seem a little foreboding. We do not expect you to know everything on the form, but we do expect you to provide all the information that is known to you.

Additional information. The form is based on the standard CDC report form. It asks for standard CDC information. In addition to the standard information, please use the comment and local field sections of the form to provide any information you may have on the following:

- Is patient newly diagnosed? If yes:
  - Why was patient tested?
  - Has the patient been informed they are HIV positive?
  - How did the patient respond to the news that they were HIV positive?
  - How is the patient coping with the news?
- Patient's living situation (Who knows about patient's HIV status? Who doesn't?)
- Patient's marital or relationship status (including HIV status of partners)
- Maintaining patient confidentiality is supremely important. With this in mind, what is the best way (e.g., a specific phone telephone number, time or place) for a trained Disease Prevention Specialist to contact the patient to deliver partner services, i.e., education about HIV, linking to care and services, and assistance in notifying partners?
- Other places the patient has lived (including military deployments if any)
- Social Security Number

Questions? Please call 515-721-8486 or 515-322-8819.

Thank you! Thank you for complying with Iowa's HIV reporting statutes!

I. Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex

Alternate Name Type (ex: Alias, Married)	*First Name	*Middle Name	*Last Name

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street	Address Date __ __/__ __/__ __ __ __

*Phone ( )	City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type	*Number

U.S. Department of Health and Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis) *Information NOT transmitted to CDC

Centers for Disease Control and Prevention (CDC)

II. Health Department Use Only (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 02/28/2026

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID	State Number

Reporting Health Dept—City/County	City/County Number

Document Source	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 6-CD/disk

III. Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name	*Phone ( )

*Street Address			
City	**County**	**State/Country**	***ZIP Code**

Facility Type

Inpatient: ☐ Hospital ☐ Other, specify _____

Outpatient: ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD clinic ☐ Other, specify _____

Other Facility: ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____

Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form	*Phone ( )

IV. Patient Demographics (record all dates as mm/dd/yyyy)

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US dependency (specify) _____
Date of Birth __ __/__ __/__ __ __ __	Alias Date of Birth __ __/__ __/__ __ __ __

Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __/__ __/__ __ __ __	State of Death

Gender Identity ☐ Man ☐ Woman ☐ Transgender man ☐ Transgender woman ☐ Additional gender identity (specify) _____ ☐ Declined to answer ☐ Unknown

Date Identified __ __/__ __/__ __ __ __

Sexual Orientation ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Additional sexual orientation (specify) _____ ☐ Declined to answer ☐ Unknown

Date Identified __ __/__ __/__ __ __ __

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity

Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race

V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

*Street Address			
City	**County**	**State/Country**	***ZIP Code**

VI. Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Check if SAME as facility providing information			
Facility Name			***Phone** ( )
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**
Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency:* ☐ CTS ☐ STD clinic ☐ Other, specify _____	*Other Facility:* ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
***Provider Name**	***Provider Phone** ( )		**Specialty**

VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ Pediatric Risk (enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received __ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____	
Other documented risk (include detail in Comments) _____	☐ Yes ☐ No ☐ Unknown

VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset __ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, describe:* _____ Date of evidence __ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays

TEST ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-2 IA

Test Brand Name/Manufacturer _____ **Lab Name** _____

Facility Name _____ **Provider Name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __

Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) *(cont)*

TEST ☐ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result ***Overall:*** ☐ Reactive ☐ Nonreactive **Collection Date** __ __ /__ __ /__ __ __ __
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive HIV-1/2 Ab: ☐ Reactive ☐ Nonreactive
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result[3] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index Value** _____ **Collection Date** __ __ /__ __ /__ __ __ __
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index Value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index Value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index Value** _____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result[4] ***Overall interpretation***: ☐ HIV positive, untypable ☐ HIV-1 positive with HIV-2 cross-reactivity ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV negative ☐ HIV indeterminate ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV-1 positive ☐ HIV-2 positive
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 WB
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

HIV Detection Tests

TEST ☐ HIV-1/2 RNA NAAT (Qualitative) **Lab Name** _____
Test Brand Name/Manufacturer _____ **Provider Name** _____
Facility Name _____ **Collection Date** __ __ /__ __ /__ __ __ __
Result ☐ HIV-1 ☐ HIV-2 ☐ Both (HIV-1 and HIV-2) ☐ HIV, not differentiated (HIV-1 or HIV-2) ☐ Neither (negative)
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA NAAT (Qualitative and Quantitative)
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result ***Qualitative:*** ☐ Reactive ☐ Nonreactive **Collection Date** __ __ /__ __ /__ __ __ __
Analyte results: HIV-1 Quantitative***:*** ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit
Copies/mL _____ **Log** _____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

TEST ☐ HIV-1 RNA/DNA NAAT (Quantitative) ☐ HIV-2 RNA/DNA NAAT (Quantitative)
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____
Result ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit ☐ Not detected **Copies/mL** _____ **Log** _____
Collection Date __ __ /__ __ /__ __ __ __
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) **Test Brand Name/Manufacturer** _____
Lab Name _____ **Facility Name** _____
Provider Name _____ **Collection Date** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test Brand Name/Manufacturer _____ **Lab Name** _____
Facility Name _____ **Provider Name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test result for this algorithm __ __ /__ __ /__ __ __ __
*Complete the above only if none of the following were positive for **HIV-1**: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

Is earliest evidence of HIV infection diagnosis documented by a physician rather than by laboratory test results? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis by physician __ __ /__ __ /__ __ __ __

Date of last documented negative HIV test result (before HIV diagnosis date) __ __ /__ __ /__ __ __ __
Specify type of test: _____
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

[2]Results not directly observed by a provider should be recorded in HIV Testing History.

[3]Complete the overall interpretation and the analyte results.

[4]Always complete the overall interpretation. Complete the analyte results when available.

X. Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown

This patient's partners will be notified about their HIV exposure and counseled by ☐ 1-Health dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown

Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments)
☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __ __/__ __/__ __ __ __

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services ☐ Yes ☐ No ☐ Unknown

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

Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown

For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)

***Child's Name**

Child's Date of Birth __ __/__ __/__ __ __ __

Child's Last Name Soundex

Child's State Number

Facility Name of Birth
(if child was born at home, enter "home birth")

***Phone**
( )

Facility Type
Inpatient: ☐ Hospital ☐ Other, specify _____
Outpatient: ☐ Other, specify _____
Other Facility: ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address**

***ZIP Code**

City

County

State/Country

XI. Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one)
☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PrEP	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PEP	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PMTCT	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ HBV Tx	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ Other (specify reason) _____			
	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __

XII. HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one)
☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever had previous positive HIV test result? ☐ Yes ☐ No ☐ Unknown **Date of first positive HIV test result** __ __/__ __/__ __ __ __

Was the first positive test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown

Ever had a negative HIV test result? ☐ Yes ☐ No ☐ Unknown **Date of last negative HIV test result** *(if date is from a lab test with test type, enter in Lab Data section)* __ __/__ __/__ __ __ __

Was the last negative test result from a self-test performed by the patient? ☐ Yes ☐ No ☐ Unknown

Number of negative HIV test results within the 24 months before the first positive test result __ __ ☐ Unknown

How many of these negative test results were from self-tests performed by the patient? __ __ ☐ Unknown

XIII. Comments

XIV. *Local/Optional Fields

This report to CDC is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).