



Austin/Travis County Health & Human Services Department

DIVISION OF THE MEDICAL DIRECTOR  
EPIDEMIOLOGY AND DISEASE SURVEILLANCE UNIT

15 Waller Street, 4<sup>th</sup> Floor

Austin, TX 78702

512-972-5555



# Reporting Communicable Disease in Travis County



Austin/Travis County Health and Human Services Department  
Communicable Disease Surveillance Program  
15 Waller Street  
Austin, Texas 78702



## Reporting Package for Providers in Travis County

### TABLE OF CONTENTS

1. Reporting Phone Numbers
2. Notifiable Conditions in Texas / Form E59-11364 (from TDSHS)
3. Reporting Forms
  - a. Notification of Diseases Reportable in Texas/Fax Form
  - b. Report of Sexually Transmitted Disease (STD) Form
  - c. Varicella Report Form
  - d. Tuberculosis Report of Case and Patient Services (TB-400A)  
*To report those with + skin test and normal X-ray*
  - e. Tuberculosis Report of Case and Patient Services (TB-400B)  
*To report those suspected of having active TB disease*
4. HIV
  - a. HIV Testing History Interview Form
  - b. Instructions for completing HIV Testing History Form
  - c. Adult HIV/AIDS Confidential Case Report
5. Laboratory Information
  - a. Reporting by Laboratories
  - b. Important Notice about bacterial isolates or specimens
6. Texas Administrative Code, Section 97.2
7. HIPAA Letter of Law to release Personal Health Information (PHI)
8. Websites related to disease reporting



## Austin/Travis County Health and Human Services Department

Communicable Disease Surveillance Program  
15 Waller Street  
Austin, Texas 78702



### REPORTING PHONE NUMBERS

Reportable diseases/conditions occurring in Travis County shall be reported to the Austin/Travis County Health and Human Services Department (ATCHHSD). Refer to the Texas Department of State Health Services (TDSHS) listing for names of diseases/conditions that are reportable and other information.

#### **General Communicable Diseases**

(512) 972-5555

Fax (512) 972-5772

Traci Perkins or Sarah Grooms

#### **HIV/AIDS**

(512) 972-5144

Fax (512) 972-5140

Justin Irving or Katherine Sosa

#### **STD Reporting**

(512) 972-5512

Fax (512) 972-6378

Bettye Martin or Tony Banire

#### **Tuberculosis Reporting**

(512) 972-5448

Fax (512) 972-5451

Marie Saldaña

#### **Perinatal Hepatitis B Program**

(512) 972-6218

Fax (512) 972-6287

Elizabeth Flagg, RN

#### **Lead (elevated blood levels)**

(512) 972-5555

Fax (512) 972-5772

### **OTHER ATCHHSD USEFUL PHONE NUMBERS**

<b>Animal Control</b>	311
<b>Environmental Health</b>	(512) 972-5600
<b>Health Authority</b>	(512) 972-5855
<b>Immunizations</b>	(512) 972-5520
<b>Refugee Screening Clinic</b>	(512) 972-6210 or 972-6239
<b>STD Clinic</b>	(512) 972-5430
<b>TB Clinic</b>	(512) 972-5460
<b>Vital Records (Birth/Death)</b>	(512) 972-4784
<b>WIC Program</b>	(512) 972-4942
<b>Vaccines for Children (Provider VFC Program)</b>	(512) 972-5414

# Texas Notifiable Conditions

**24/7 Number for Immediately Reportable– 1-800-705-8868**  
Report confirmed and suspected cases.



Unless noted by \*, report to your local or regional health department using number above or find contact information at <http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/>

A – L	When to Report	L – Y	When to Report
*Acquired immune deficiency syndrome (AIDS) <sup>1, 2</sup>	Within 1 week	Leishmaniasis <sup>3</sup>	Within 1 week
Amebiasis <sup>3</sup>	Within 1 week	Listeriosis <sup>3, 4</sup>	Within 1 week
<b>Anthrax<sup>3, 4</sup></b>	<b>Call Immediately</b>	Lyme disease <sup>3</sup>	Within 1 week
Arbovirus infection <sup>3, 5</sup>	Within 1 week	Malaria <sup>3</sup>	Within 1 week
*Asbestosis <sup>6</sup>	Within 1 week	<b>Measles (rubeola)<sup>3</sup></b>	<b>Call Immediately</b>
<b>Botulism, foodborne<sup>3</sup></b>	<b>Call Immediately</b>	Meningitis (specify type) <sup>3</sup>	Within 1 week
Botulism, infant, wound, and other <sup>3</sup>	Within 1 week	<b>Meningococcal infections, invasive<sup>3, 4</sup></b>	<b>Call Immediately</b>
<b>Brucellosis<sup>3, 4</sup></b>	<b>Within 1 work day</b>	Mumps <sup>3</sup>	Within 1 week
Campylobacteriosis	Within 1 week	<b>Pertussis<sup>3</sup></b>	<b>Within 1 work day</b>
*Cancer <sup>7</sup>	See rules	*Pesticide poisoning, acute occupational <sup>6</sup>	Within 1 week
*Chancroid	Within 1 week	<b>Plague (<i>Yersinia pestis</i>)<sup>3, 4</sup></b>	<b>Call Immediately</b>
Chickenpox (varicella) <sup>8</sup>	Within 1 week	<b>Poliomyelitis, acute paralytic<sup>3</sup></b>	<b>Call Immediately</b>
* <i>Chlamydia trachomatis</i> infection	Within 1 week	<b>Q fever<sup>3</sup></b>	<b>Within 1 work day</b>
*Chromosomal results (fetus and infant only) <sup>9</sup>	See rules	<b>Rabies, human<sup>3</sup></b>	<b>Call Immediately</b>
*Contaminated sharps injury <sup>10</sup>	Within 1 month	Relapsing fever <sup>3</sup>	Within 1 week
<b>*Controlled substance overdose<sup>11</sup></b>	<b>Call Immediately</b>	<b>Rubella (including congenital)<sup>3</sup></b>	<b>Within 1 work day</b>
Creutzfeldt-Jakob disease (CJD)	Within 1 week	Salmonellosis, including typhoid fever <sup>3</sup>	Within 1 week
Cryptosporidiosis	Within 1 week	<b>Severe Acute Respiratory Syndrome (SARS)<sup>3</sup></b>	<b>Call Immediately</b>
Cyclosporiasis	Within 1 week	Shigellosis <sup>3</sup>	Within 1 week
Cysticercosis	Within 1 week	*Silicosis <sup>6</sup>	Within 1 week
Dengue	Within 1 week	<b>Smallpox<sup>3</sup></b>	<b>Call Immediately</b>
<b>Diphtheria</b>	<b>Call Immediately</b>	*Spinal cord injury	Within 10 work days
*Drowning/near drowning <sup>12</sup>	Within 10 work days	Spotted fever group rickettsioses <sup>3</sup>	Within 1 week
Ehrlichiosis	Within 1 week	<b>Staph. aureus, vancomycin-resistant (VISA and VRSA)<sup>3, 4</sup></b>	<b>Call Immediately</b>
Encephalitis (specify etiology)	Within 1 week	Streptococcal disease (group A, B, S. <i>pneumo</i> ), invasive <sup>3</sup>	Within 1 week
<i>Escherichia coli</i> , enterohemorrhagic <sup>3, 4</sup>	Within 1 week	<b>*Syphilis – primary and secondary stages<sup>1, 13</sup></b>	<b>Call within 1 work day</b>
*Gonorrhea	Within 1 week	*Syphilis – all other stages <sup>1, 13</sup>	Within 1 week
<b><i>Haemophilus influenzae</i> type b infections, invasive<sup>3</sup></b>	<b>Call Immediately</b>	<i>Taenia solium</i> and undifferentiated <i>Taenia</i> infection <sup>3</sup>	Within 1 week
Hansen's disease (leprosy) <sup>3</sup>	Within 1 week	Tetanus <sup>3</sup>	Within 1 week
Hantavirus infection <sup>3</sup>	Within 1 week	*Traumatic brain injury	Within 10 work days
Hemolytic Uremic Syndrome (HUS) <sup>3</sup>	Within 1 week	Trichinosis <sup>3</sup>	Within 1 week
<b>Hepatitis A<sup>3</sup></b>	<b>Within 1 work day</b>	<b>Tuberculosis (includes all <i>M. tuberculosis</i> complex)<sup>4, 14</sup></b>	<b>Within 1 work day</b>
Hepatitis B, C, D, E, and unspecified (acute) <sup>3</sup>	Within 1 week	<b>Tularemia<sup>3, 4</sup></b>	<b>Call Immediately</b>
Hepatitis B identified prenatally or at delivery (acute & chronic) <sup>3</sup>	Within 1 week	Typhus <sup>3</sup>	Within 1 week
<b>Hepatitis B, perinatal (HBsAg+ &lt; 24 months old)<sup>3</sup></b>	<b>Within 1 work day</b>	<b><i>Vibrio</i> infection, including cholera<sup>3, 4</sup></b>	<b>Within 1 work day</b>
*Human immunodeficiency virus (HIV) infection <sup>1, 2</sup>	Within 1 week	<b>Viral hemorrhagic fever, including Ebola<sup>3</sup></b>	<b>Call Immediately</b>
<b>Influenza-associated pediatric mortality<sup>3</sup></b>	<b>Within 1 work day</b>	West Nile Fever <sup>3</sup>	Within 1 week
<b>*Lead, child blood, any level &amp; adult blood, any level<sup>6</sup></b>	<b>Call/Fax Immediately</b>	<b>Yellow fever<sup>3</sup></b>	<b>Call Immediately</b>
Legionellosis <sup>3</sup>	Within 1 week	Yersiniosis <sup>3</sup>	Within 1 week

**In addition to specified reportable conditions, any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported by the most expeditious means available**

**\*See condition-specific footnote for reporting contact information**

- <sup>1</sup> Please refer to specific rules and regulations for HIV/STD reporting and who to report to at: <http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm>.
- <sup>2</sup> Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3041 for details.
- <sup>3</sup> Reporting forms are available at <http://www.dshs.state.tx.us/idcu/investigation/forms/>. Investigation forms at <http://www.dshs.state.tx.us/idcu/investigation/>. Call as indicated for immediately reportable conditions.
- <sup>4</sup> Lab isolate must be sent to DSHS lab. Call 512-458-7598 for specimen submission information.
- <sup>5</sup> Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive California serogroup, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), West Nile, and Western Equine (WEE).
- <sup>6</sup> Please refer to specific rules and regulations for environmental and toxicology reporting and who to report to at <http://www.dshs.state.tx.us/epitox/default.shtm>.
- <sup>7</sup> Please refer to specific rules and regulations for cancer reporting and who to report to at <http://www.dshs.state.tx.us/tcr/lawrules.shtm>.
- <sup>8</sup> Varicella reporting form is at [http://www.dshs.state.tx.us/idcu/health/vaccine\\_preventable\\_diseases/forms/f11\\_11046.pdf](http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/forms/f11_11046.pdf). Call local health dept for copy with their fax number.
- <sup>9</sup> Please refer to specific rules and regulations for birth defects reporting and who to report to at [http://www.dshs.state.tx.us/birthdefects/BD\\_LawRules.shtm](http://www.dshs.state.tx.us/birthdefects/BD_LawRules.shtm).
- <sup>10</sup> Not applicable to private facilities. Initial reporting forms for Contaminated Sharps at [http://www.dshs.state.tx.us/idcu/health/infection\\_control/bloodborne\\_pathogens/reporting/](http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting/).
- <sup>11</sup> Contact local poison center at 1-800-222-1222. For instructions, forms, and fax numbers see <http://www.dshs.state.tx.us/epidemiology/epipoison.shtm#rcso>.
- <sup>12</sup> Please refer to specific rules and regulations for injury reporting and who to report to at <http://www.dshs.state.tx.us/injury/default.shtm>.
- <sup>13</sup> Laboratories should report syphilis test results within 3 work days of the testing outcome.
- <sup>14</sup> MTB complex includes *M.tuberculosis*, *M.bovis*, *M.africanum*, *M.canettii*, *M.microti*, *M.caprae*, and *M.pinnipedii*. Please see rules at <http://www.dshs.state.tx.us/idcu/disease/tb/>.

Texas Department of State Health Services – Business Hours 1-800-252-8239 / After Hours 512-458-7111



## Notifiable Conditions Special Instructions

<sup>1</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/hivstd/reporting/default.shtm>

<sup>2</sup> Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3041 for details.

<sup>3</sup> Reporting and investigation forms are available at: <http://www.dshs.state.tx.us/idcu/investigation/>

Call as indicated for immediately reportable conditions.

<sup>4</sup> Lab isolate must be sent to DSHS lab. Call 512-458-7598 for specimen submission information

<sup>5</sup> Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive Cache Valley, California serogroup, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), Venezuelan equine (VEE), West Nile, and Western Equine (WEE)

<sup>6</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/epitox/default.shtm>

<sup>7</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/tcr/lawrules.shtm>

<sup>8</sup> Varicella reporting form is at:

[http://www.dshs.state.tx.us/idcu/health/vaccine\\_preventable\\_diseases/forms/f11\\_11046.pdf](http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/forms/f11_11046.pdf). Call local health

dept for copy with their fax number. <sup>9</sup> Not applicable to private facilities. Initial reporting forms for Contaminated

Sharps at: [http://www.dshs.state.tx.us/idcu/health/bloodborne\\_pathogens/reporting/](http://www.dshs.state.tx.us/idcu/health/bloodborne_pathogens/reporting/)

<sup>10</sup> Contact local poison center at 1-800-222-1222. For instructions, forms, and fax numbers see

<http://www.dshs.state.tx.us/epidemiology/epipoison.shtm>

<sup>11</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/injury/default.shtm>

<sup>12</sup> M. TB complex includes *M. tuberculosis*, *m. bovis*, and *m. africanum*. Please refer to specific rules and regulations for reporting and who to report to at <http://www.dshs.state.tx.us/idcu/disease/tb/>

In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported** by the most expeditious means available

DEPARTMENT OF STATE HEALTH SERVICES CONFIDENTIAL REPORT (FAX VERSION ONLY)

All physicians who diagnose or treat a reportable condition and others required to report shall report it within seven (7) days. Complete <u>all</u> boxes as appropriate. Shaded areas are <u>not</u> required by law, but necessary for appropriate identification or follow-up					
Patient's Name (Last, First, MI)		Birth Date (mm/dd/yyyy)	Age	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Pregnant? Y <input type="checkbox"/> # of weeks N <input type="checkbox"/>
Address (Street, City, State, Zip)		Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>		Race: <i>check all that apply</i> W <input type="checkbox"/> B <input type="checkbox"/> AIS <input type="checkbox"/> AI <input type="checkbox"/> PI <input type="checkbox"/>	
Telephone:	Employment	Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>		SSN or Medical Record#	
Exam Date: (mm/dd/yyyy)	Provider <input type="checkbox"/> 900 Clinic <input type="checkbox"/> 100-200-300-700 Clinic <input type="checkbox"/> Drug Treatment <input type="checkbox"/> Family Planning Sites Codes: <input type="checkbox"/> Prenatal/OB Clinic <input type="checkbox"/> TB Clinic <input type="checkbox"/> Other Clinic <input type="checkbox"/> Private Phy/HMO <input type="checkbox"/> Hospital <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Laboratory <input type="checkbox"/> Blood/Plasma <input type="checkbox"/> Other				
Lab Test(s) and Results:	Exam Reason: <input type="checkbox"/> DIS Partner Referral <input type="checkbox"/> DIS Suspect Referral <input type="checkbox"/> Referred by Partner <input type="checkbox"/> Prenatal <input type="checkbox"/> Delivery <input type="checkbox"/> Screening in Jail/Prison <input type="checkbox"/> Other Screening <input type="checkbox"/> Referred by Another Provider <input type="checkbox"/> Volunteer				
	Treatment Given (Drug and Dosage):		Date: (mm/dd/yyyy)		<input type="checkbox"/> No Treatment Given
Code 100 <input type="checkbox"/>	Code 490 Associated with <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> Other or Unknown Etiology		Code: <input type="checkbox"/> 900 <input type="checkbox"/> 950		
Code 200 (not 490) <input type="checkbox"/> Genital <input type="checkbox"/> Ophthalmia	Code 300 (not 490) <input type="checkbox"/> Genital <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Other <input type="checkbox"/> Resistant		Code <input type="checkbox"/> 710 <input type="checkbox"/> 720 <input type="checkbox"/> 730 <input type="checkbox"/> 740 <input type="checkbox"/> 745 <input type="checkbox"/> 750 <input type="checkbox"/> 790		
Reported by:	Code 600 <input type="checkbox"/>		<input type="checkbox"/> Send my office additional cards  <p style="text-align: center;"><b>Faxable S-27 Form</b></p>		
Name	Neurologic Involvement <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk				
Office Address	City	Phone Number			

Region 7- Temple, Texas  
 Fax: 254-771-1768  
 Phone: 254-771-6786

City of Austin Health Department  
 Fax: 512-972-6378  
 Phone: 512-972-5512  
 512-972-5433

100 – Chancroid  
200 – Chlamydia  
300 – Gonorrhea  
490 – Pelvic Inflammatory Disease (Syndrome)  
600 – Lymphogranuloma Venereum  
700 – Syphilis  
710 – Primary Syphilis (lesions)  
720 – Secondary Syphilis (symptoms)  
730 – Early Latent Syphilis (<1 year)  
740 – Latent Syphilis, Unknown Duration  
745 – Late Latent Syphilis (>1 year)  
750 – Late Syphilis with Symptomatic Manifestations  
790 – Congenital Syphilis  
900 – HIV (non-AIDS)  
950 – AIDS (Syndrome)

100 – Chancroid  
200 – Chlamydia  
300 – Gonorrhea  
490 – Pelvic Inflammatory Disease (Syndrome)  
600 – Lymphogranuloma Venereum  
700 – Syphilis  
710 – Primary Syphilis (lesions)  
720 – Secondary Syphilis (symptoms)  
730 – Early Latent Syphilis (<1 year)  
740 – Latent Syphilis, Unknown Duration  
745 – Late Latent Syphilis (>1 year)  
750 – Late Syphilis with Symptomatic Manifestations  
790 – Congenital Syphilis  
900 – HIV (non-AIDS)  
950 – AIDS (Syndrome)

100 – Chancroid  
200 – Chlamydia  
300 – Gonorrhea  
490 – Pelvic Inflammatory Disease (Syndrome)  
600 – Lymphogranuloma Venereum  
700 – Syphilis  
710 – Primary Syphilis (lesions)  
720 – Secondary Syphilis (symptoms)  
730 – Early Latent Syphilis (<1 year)  
740 – Latent Syphilis, Unknown Duration  
745 – Late Latent Syphilis (>1 year)  
750 – Late Syphilis with Symptomatic Manifestations  
790 – Congenital Syphilis  
900 – HIV (non-AIDS)  
950 – AIDS (Syndrome)

100 – Chancroid  
200 – Chlamydia  
300 – Gonorrhea  
490 – Pelvic Inflammatory Disease (Syndrome)  
600 – Lymphogranuloma Venereum  
700 – Syphilis  
710 – Primary Syphilis (lesions)  
720 – Secondary Syphilis (symptoms)  
730 – Early Latent Syphilis (<1 year)  
740 – Latent Syphilis, Unknown Duration  
745 – Late Latent Syphilis (>1 year)  
750 – Late Syphilis with Symptomatic Manifestations  
790 – Congenital Syphilis  
900 – HIV (non-AIDS)  
950 – AIDS (Syndrome)

## VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella by faxing a copy of this document to the Austin-Travis County Health and Human Services Department at the end of every week.

**FAX: (512) 972-5772**

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

<b>ONSET DATE</b>	<b>VACCINATED AGAINST VARICELLA?</b> Yes    No <b>Number of Doses Received?</b> 1    2 Date(s) Varicella Vaccine Administered:    ____ / ____ / ____ , ____ / ____ / ____			
<b>LAST NAME</b>	<b>FIRST</b>	<b>DOB</b>	<b>SEX</b>	<b>RACE</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>ZIP CODE</b>	<b>HISPANIC?</b> Yes                  No	

**AGENCY REPORTED BY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_

**DATE REPORTED:** \_\_\_\_\_

**Texas Department of Health  
Tuberculosis Elimination Division  
Report of Case and Patient Services**

Date reported to health department \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to region \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to central office \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Initial Report       Hospital Admission  
 Address Change       Name Change (show new name and draw single line through old)       Other Change (please circle)

SSN \_\_\_\_\_ Medicaid # \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) AKA \_\_\_\_\_

Street \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_ Patient's Tel.# \_\_\_\_\_

Facility/Care Provider Name \_\_\_\_\_  
Initial Reporting Source  Health Dept       Private Physician       Public Hospital       VA Hospital      Name of person completing this form \_\_\_\_\_  
 Military Hospital       TDCJ       Other (Specify) \_\_\_\_\_

<b>Country of Birth</b> _____ If foreign born, Date of entry into U.S. _____ / _____ / _____	<b>Notice of Arrival of Alien with TB Class</b> <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	<b>Reported at Death</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Death Date _____ / _____ / _____ Was TB cause of death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<b>Reported Out of State or Country</b> <input type="checkbox"/> Yes Specify _____ <input type="checkbox"/> No
<b>Preferred Language</b> _____	<b>ETHNICITY</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

**RACE (check all that apply)**  
 White       Native Hawaiian or Pacific Islander  
 Black or African American       American Indian or Alaskan Native  
 Asian       Unknown

**OCCUPATION (within past 2 years)**  
 Unemployed during last 2 yrs       Unknown  
 Employed (If employed, check all that apply)  
 Migrant/Seasonal Worker       Student       Child  
 Health Care Worker (Specify) \_\_\_\_\_       Retiree       Disabled  
 Correctional Emp       Other Occupation \_\_\_\_\_       Homemaker  
 Institutionalized

**Resident of Correctional Facility at Time of Dx**     Yes     No     Unknown    Incarceration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
If Yes     Federal Prison     State Prison     County Jail     City Jail     Juvenile Correctional Facility     ICE     Other

**Resident of Long Term Care Facility at Time of Dx**     Yes     No     Unknown  
If Yes     Nursing Home     Hospital-Based Facility     Residential Facility     Mental Health Residential Facility  
 Alcohol/Drug Treatment Facility     Other Long Term Care Facility

**Testing activities to find latent TB infections**  
 Patient referred, TB infection     Project targeted testing     Individual targeted testing     Administrative: Not at risk for TB

<b>POPULATION RISKS</b> <input type="checkbox"/> Low income <input type="checkbox"/> Inner-city resident <input type="checkbox"/> Foreign born <input type="checkbox"/> Binational (US-Mexico) *Within past 2 years <input type="checkbox"/> Correctional employee* <input type="checkbox"/> Health care worker* <input type="checkbox"/> Prison/Jail inmate* <input type="checkbox"/> Long-term facility for elderly/resident* <input type="checkbox"/> Health care facility/resident* <input type="checkbox"/> Shelter for homeless persons* <input type="checkbox"/> Migrant farm worker* <input type="checkbox"/> None of the above risks apply	<b>MEDICAL RISKS</b> <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Alcohol Abuse (within past year) <input type="checkbox"/> Tobacco use _____ <input type="checkbox"/> Silicosis <input type="checkbox"/> Corticosteroids or other immunosuppressive therapy <input type="checkbox"/> Gastrectomy or jejunioileal bypass <input type="checkbox"/> age ≤5 years <input type="checkbox"/> Recent exposure to TB (Contact to TB case) <input type="checkbox"/> Contact to MDR-TB case <input type="checkbox"/> Weight at least 10% less than ideal body weight <input type="checkbox"/> Chronic malabsorption syndromes	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Cancer of head <input type="checkbox"/> Cancer of neck <input type="checkbox"/> Drug abuse within past year: <input type="checkbox"/> Injecting <input type="checkbox"/> Non-injecting <input type="checkbox"/> Unknown if injecting <input type="checkbox"/> HIV seropositive (check only if laboratory confirmed) <input type="checkbox"/> Tuberculin skin test conversion within 2 years <input type="checkbox"/> Fibrotic lesions (on chest x-ray) consistent with old, healed TB	<input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Other _____ <input type="checkbox"/> None of these medical risks apply
<b>HIV TEST RESULTS</b> Date HIV Test _____ / _____ / _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Refused <input type="checkbox"/> Not Offered Date CD4 Count _____ / _____ / _____ Results CD4 Count _____			

**TUBERCULIN SKIN TEST** Documented history of positive TST?     Yes     No  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ mm     Positive     Negative     Not Read  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ mm     Positive     Negative     Not Read

**PRIOR LTBI TREATMENT**     Yes     No  
Start Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Stop Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**FOR TREATMENT OF LTBI ONLY**  
DOPT:     Yes, totally observed     No, self-administered     Both    Date Normal Chest X-ray \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Weight \_\_\_\_\_    Height \_\_\_\_\_  
DOPT Site:     Clinic or medical facility     Field     Both    **ATS Classification**  
Frequency:     Daily     Twice Weekly     Three X's Weekly     0 No M. TB Exposure, Not TB Infected  
 1 M. TB Exposure, No Evidence of TB Infection  
 2 M. TB Infection, No Disease  
 4 M. TB, No Current Disease

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Start    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Stop  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Restart    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Stop

Isoniazid \_\_\_\_\_ mgs     Other (specify) \_\_\_\_\_ mgs  
 Rifampin \_\_\_\_\_ mgs     Other (specify) \_\_\_\_\_ mgs  
 B6 \_\_\_\_\_ mgs    Prescribed for: \_\_\_\_\_ months    Maximum refills authorized: \_\_\_\_\_    Physician Signature \_\_\_\_\_    Date \_\_\_\_\_

**CLOSURE:** Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Completion adequate therapy    \_\_\_\_\_ # months on Rx    \_\_\_\_\_ # months recommended  
 Lost to followup     Patient chose to stop     Deceased (Cause) \_\_\_\_\_  
 Adverse Drug Reaction     Moved out of state/country to: \_\_\_\_\_

Provider decision:     Pregnant     Non-TB     Other: \_\_\_\_\_





HIV Testing/Treatment History Interview Form Required to Estimate HIV Incidence

Local Public Health Use
State No: \_\_\_\_\_

Please complete the following information for each person ≥13 years of age who is newly diagnosed with HIV infection.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Collection date for test initiating current public health follow-up \_\_\_\_\_

Specimen Type (Confirmatory Test): [ ] Blood (venipuncture) [ ] Blood (fingerstick) [ ] Blood (spot) [ ] Blood (plasma) [ ] Oral fluid [ ] Urine

Person Completing Form: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Provider/facility Collecting Specimen: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Please ask each person who is newly diagnosed with HIV infection the questions in the box below. This information about previous testing behavior is used by public health officials to estimate the level of new HIV infection in the general population. All information is kept private. Thank you.

Today's Date: \_\_\_\_\_

1) When was your very first positive HIV test? [ ] / [ ] [ ] You do not want to say [ ] You do not know

1a) Clinic or physician's office of your first positive HIV test: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

2) Have you ever had an HIV test that was negative? [ ] Yes [ ] No (go to 3) [ ] You don't want to say (go to 3) [ ] You don't know (go to 3)

2a) If yes, what was the month/year of your last negative? [ ] / [ ] [ ] You don't want to say [ ] You don't know

2b) How many HIV tests did you have within the 2 years before your first positive test (date in question 1)?

[ ] + [ 1 ] = [ ] [ ] You do not want to say [ ] You do not know
Negative Tests For 1st Positive Total

3) BEFORE YOUR FIRST POSITIVE TEST, have you taken antiretroviral (ARV) medicines to treat or prevent HIV infection or medicines to treat Hepatitis B? A list is provided on the back of this form.

[ ] Yes [ ] No [ ] You do not want to say [ ] You do not know

3a) First day ARV medications taken? [ ] / [ ] / [ ]

3b) Last day ARV medications taken: [ ] / [ ] / [ ]

3c) Please list all ARV or Hepatitis B medications taken by this patient BEFORE THE FIRST POSITIVE TEST in Question 1. A list is provided on the back of this form.

[ ] [ ] [ ] [ ] [ ]

Copies of this form may be obtained from your local or regional health department. Please submit the completed form as directed by your local or regional health department. Photocopies are accepted. Thank you

DSHS Use Only: Received: \_\_\_\_\_ Logged: \_\_\_\_\_ Entered: \_\_\_\_\_ Closed: \_\_\_\_\_

## Antiretrovirals and Other Medications Historically Prescribed to Treat HIV or Other Viral Infections

<p><b>Protease Inhibitors (PI's)</b></p> <p><input type="checkbox"/> Amprenavir (Agenerase; APV)</p> <p><input type="checkbox"/> Atazanavir (Reyataz; ATV)</p> <p><input type="checkbox"/> Darunavir (Prezista; TMC114, DRV)</p> <p><input type="checkbox"/> Fosamprenavir (Lexiva; FPV, 908)</p> <p><input type="checkbox"/> Indinavir (Crixivan; IDV)</p> <p><input type="checkbox"/> Lopinavir/ritonavir (Kaletra; LPV/r)</p> <p><input type="checkbox"/> Nelfinavir (Viracept; NFV)</p> <p><input type="checkbox"/> Ritonavir (Norvir; RTV)</p> <p><input type="checkbox"/> Saquinavir - hard gel cap (Invirase; SQV(HGC))</p> <p><input type="checkbox"/> Saquinavir - unspecified type of gel cap (SQV)</p> <p><input type="checkbox"/> Tipranavir (Aptivus; TPV)</p> <p><b>Non Nucleoside Reverse Transcriptase Inhibitors (nNRTI)</b></p> <p><input type="checkbox"/> Delavirdine (Rescriptor; DLV)</p> <p><input type="checkbox"/> Efavirenz (Sustiva; EFV)</p> <p><input type="checkbox"/> Efavirenz + emtricitabine + tenofovir (Atripla; EFV + FTC + TDF)</p> <p><input type="checkbox"/> Nevirapine (Viramune; NVP)</p> <p><b>Historically Prescribed or Relating to Other Viral Conditions:</b></p> <p><input type="checkbox"/> Hydroxyurea (Hydrea, Droxia; not approved for HIV treatment)</p> <p><input type="checkbox"/> Saquinavir - soft gel cap (Fortovase; SQV(SGC))</p> <p><input type="checkbox"/> Adefovir (Hepsera; Hepatitis B treatment)</p>	<p><b>Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTI)</b></p> <p><input type="checkbox"/> Abacavir (Ziagen; ABC)</p> <p><input type="checkbox"/> Abacavir + lamivudine (Epzicom; ABC + 3TC)</p> <p><input type="checkbox"/> Abacavir + zidovudine + lamivudine (Trizivir; ABC + AZT + 3TC)</p> <p><input type="checkbox"/> Didanosine (VIDEX or VIDEX EC delayed release; ddI)</p> <p><input type="checkbox"/> Emtricitabine (Emtriva; FTC)</p> <p><input type="checkbox"/> Lamivudine (Epivir; 3TC)</p> <p><input type="checkbox"/> Stavudine (Zerit or Zerit XR delayed-release; d4T)</p> <p><input type="checkbox"/> Tenofovir (Viread; TDF)</p> <p><input type="checkbox"/> Tenofovir + emtricitabine (Truvada; TDF + FTC)</p> <p><input type="checkbox"/> Zalcitabine (Hivid; ddC)</p> <p><input type="checkbox"/> Zidovudine (Retrovir; AZT or ZDV)</p> <p><input type="checkbox"/> Zidovudine + lamivudine (Combivir; AZT + 3TC)</p> <p><b>Entry / Fusion / Other Inhibitors</b></p> <p><input type="checkbox"/> Enfuvirtide (Fuzeon; ENF, T20)</p> <p><input type="checkbox"/> Maraviroc (Selzentry)</p> <p><input type="checkbox"/> Raltegravir (Isentress)</p> <p><input type="checkbox"/> Other Antiretroviral (specify _____)</p>
--	---

*If needed, please provide pictures of medications to the patient.  
A source for a pill chart is: <http://www.crine.org/info/CRIPillChart.pdf>.*

*Copies of this form may be obtained from your local or regional health department. Please submit the completed form as directed by your local or regional health department. Photocopies are accepted. Thank you*

## Instructions for Completing the HIV Testing & Treatment History (TTH) Questionnaire

The purpose of the TTH is to supplement the adult HIV/AIDS case report form with information necessary to estimate HIV incidence. **Complete a TTH form for all new positive diagnoses after 06/01/2005.**

**Information gathered for the TTH must come from an interview and/or medical chart abstraction.**

Please keep the TTH forms long enough to complete them, but efforts should be made to submit the forms to Central Office within 30 days of learning about a case. Surveillance staff should check STD\*MIS within 10 days to determine if the case has been assigned to a DIS, and should then check STD\*MIS again periodically prior to the close of the 30 day period to verify whether or not the patient was interviewed.

### Patient Interviews

DIS, CBOs, or other providers will no longer record testing and treatment history information on the Interview Form. Rather, the information should be documented on the TTH form and forwarded to the HIV surveillance staff. The individual conducting the interview should provide his/her name in the "DIS Patient Interview-Person conducting interview" field.

The following details all information required on the TTH by section. Please fill in the form as completely as possible.

- **Date Form Completed:** Fill in month, day and year completely
- **Patient Stateno:** Fill in the StateNo for the patient. This field should only be completed by the HIV Surveillance Staff.

### I. Patient Identification

- **Last Name, First Name:** Write patient's last name and first name in the fields provided
- **MI:** Write the patient's middle initial if available
- **Date of Birth:** Fill in numbers corresponding to the month, day, and two-digit year of birth in the designated boxes. (Jan=01, Feb=02, etc) ; Example: June 8, 1955=06 08 55
- **Date of Current HIV Test:** Fill in numbers corresponding to the month, day, and two-digit year of the current HIV test in the designated boxes.

### II. First Positive Test

- **Date of First positive HIV test:** Enter the date (MM/DD/YYYY) of the **first positive** HIV test. If the current test is the first positive test, then enter the date of the current test. **Self-reported dates are acceptable.**

### III. Previous HIV Tests

- **Has the patient ever tested negative for HIV:** Check whether the patient has ever tested negative for HIV (yes, no or unknown). **Self-reported information is acceptable.**
  - If yes, then enter the date (MM/YYYY) of the **last negative** test. If the month is unknown, leave the month blank and just enter the year.
  - Unknown should only be marked if the patient did not know if s/he has ever tested negative or all potential sources of information were reviewed and there was no information about the patient's negative tests history.
  - If Unknown is marked, **do not** answer the next question "In the 2 years before the patient's 1<sup>st</sup> positive test, how many times did the patient get tested for HIV"
  - Last negative refers to a negative confirmatory test
- **In the 2 years before the patient's 1<sup>st</sup> positive test, how many times did the patient get tested for HIV:** Indicate the number of times the patient has tested in the **two years** before his/her first positive test (include the first positive test in the count). To compute the total, enter the number of negative tests during the two years before the first positive and add to the first positive test.
  - Example 1: If a patient's first positive test was today and he indicates that he tested 3 other times in the past two years, his total will be 4 tests.
  - Example 2: If a patient's first positive test was also his first ever test, his total will be 1 test.
  - Example 3: If a patient's first positive test was today and he indicates that he has had 5 previous negative tests. However he only tests about once a year, so only 1 other test was in the past two years. His total will then be 2 tests.

- Example 4: Patient first tested positive in 2005. In the two years before his **first positive test** he had 2 negative tests. His total will be 3 tests.

#### IV. Antiretroviral Medications

- **Has the patient ever taken any Antiretroviral medications?** Check whether the patient has taken any antiretroviral medications prior to his/her first positive test. This includes highly active-antiretroviral therapy (HAART) or ARV, some medications for Hepatitis B, and post-exposure prophylaxis (PEP) for HIV. Self-reported data are acceptable.
  - If yes, then list the medications
  - If yes, then indicate the start date (MM/DD/YYYY). If exact date is unknown include the month and year or just year.
  - If yes, then indicate the end date (MM/DD/YYYY). If exact date is unknown include the month and year or just year.
  - If the patient is currently taking medications and has not completed the regimen check the Currently Taking check box and leave the end date field blank.

#### V. Primary Source of Information

- Check the appropriate box to indicate the source of information for the TTH form: DIS Patient Interview, Medical Chart Abstraction, or Abstraction of DIS Interview Notes. At least one box must be checked.
  - If you work for STD surveillance as a DIS who conducts patient interviews, then check the "DIS Patient Interview" box
  - If you are a HARS surveillance staff member, check either the "Medical Chart Abstraction" box, the "Abstraction of DIS Interview Notes" box, or both.
    - The "Abstraction of DIS Interview Notes" is for HARS surveillance staff who can get the physical DIS interview notes (i.e., not notes entered into STD\*MIS) from the DIS who conducted the patient interview to abstract information for the TTH form.
  - If there are multiple sources check both boxes.
  - Fill out the name of the person completing the interview or abstraction and date in the field provided.

#### VI. Additional Source of Information

- If additional information is gathered from sources other than the patient interview or medical chart abstraction, check the appropriate box to indicate the source of additional information: STD/MIS Abstraction or Other
  - If there are multiple sources check both boxes.
  - If STD/MIS Abstraction is checked, enter the name of the person completing the abstraction.
  - If Other is selected, then indicate what the source was in the field provided

#### Additional Notes

- Please include any comments or questions in this section.

#### Mail in completed forms

- DIS/Providers should forward the TTH form to the local HIV Surveillance Program
- HIV Surveillance Staff should send the form to DSHS in Austin, TX

If you have any questions, please contact the technical assistance team from UT Southwestern. Their contact information is listed below.

Thank you for your hard work!

Mariama Janneh  
214-645-7362  
[Mariama.janneh@utsouthwestern.edu](mailto:Mariama.janneh@utsouthwestern.edu)

Douglas Shehan  
214-645-7309  
[Douglas.shehan@utsouthwestern.edu](mailto:Douglas.shehan@utsouthwestern.edu)

Date Received (Central Office Use):

# Texas Adult HIV/AIDS Confidential Case Report Form

(≥13 years of age at time of diagnosis)

Report Status:

- New Case     Other Update  
 Update to AIDS

TDCJ Case:     Yes     No

Stateno: \_\_\_\_\_

## I. FORM INFORMATION

<b>Document Source:</b> _____	<b>Report Medium:</b> <input type="checkbox"/> Field Visit <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Disk-CD <input type="checkbox"/> Electronic	<b>Surveillance Method:</b> <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow-up <input type="checkbox"/> Re-abstraction	<b>Date Form Completed:</b> Mo.   Day   Yr. [ ][ ] [ ][ ] [ ][ ]	<b>Person Completing Form:</b> _____
<b>Facility Where Information Was Obtained:</b> <input type="checkbox"/> New Facility (not on fac. list)				
Facility Name: _____				
Street Address: _____ City: _____ State: _____ ZIP: _____				
<b>Facility Type:</b> <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Private Phys <input type="checkbox"/> Infect Disease Clinic <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> HIV Counsel/ Test <input type="checkbox"/> STD Clinic <input type="checkbox"/> Blood Bank <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other: _____				<b>Facility Setting:</b> <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County

## II. NAME

**Name Type:**    Legal    Alias    Maiden    Nickname    Married    Other: \_\_\_\_\_

**Name:** First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_

**Name Type:**    Legal    Alias    Maiden    Nickname    Married    Other: \_\_\_\_\_

**Name:** First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_

## III. ADDRESS

**Address Type:**  
 Residential    Correctional    Homeless  
 Postal    Temporary    Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

## IV. IDs

<b>ID Type:</b> <input type="checkbox"/> SSN <input type="checkbox"/> Alt SSN <input type="checkbox"/> Other: _____	<b>ID:</b>
<input type="checkbox"/> STD*MIS <input type="checkbox"/> Med Rec # <input type="checkbox"/> Prison ID	
<input type="checkbox"/> SSN <input type="checkbox"/> Alt SSN <input type="checkbox"/> Other: _____	
<input type="checkbox"/> STD*MIS <input type="checkbox"/> Med Rec # <input type="checkbox"/> Prison ID	
<input type="checkbox"/> SSN <input type="checkbox"/> Alt SSN <input type="checkbox"/> Other: _____	
<input type="checkbox"/> STD*MIS <input type="checkbox"/> Med Rec # <input type="checkbox"/> Prison ID	

## V. DEMOGRAPHIC INFORMATION

<b>Diagnostic Status:</b> <input type="checkbox"/> HIV (not AIDS) <input type="checkbox"/> AIDS	<b>Sex at Birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth:</b> Mo.   Day   Yr. [ ][ ] [ ][ ] [ ][ ]	<b>Alias Date of Birth:</b> Mo.   Day   Yr. [ ][ ] [ ][ ] [ ][ ]	<b>Country of Birth:</b> <input type="checkbox"/> USA <input type="checkbox"/> Other (specify): _____
<b>Vital Status:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<b>Date of Death:</b> Mo.   Day   Yr. [ ][ ] [ ][ ] [ ][ ]	<b>St of Death:</b> [ ][ ]	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unk <input type="checkbox"/> Not Hispanic/Latino	<b>Race:</b> <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Black/ African American <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <b>Extended Race:</b> _____

## VI. RESIDENCE AT DIAGNOSIS

<b>HIV Residence:</b> <input type="checkbox"/> Same as current add.	<b>AIDS Residence:</b> <input type="checkbox"/> Same as current add. <input type="checkbox"/> Same as HIV Res.
Address: _____ City: _____	Address: _____ City: _____
State: _____ Zip: _____ County: _____	State: _____ Zip: _____ County: _____

## VII. FACILITY OF DIAGNOSIS

Statenö: \_\_\_\_\_

<b>HIV Diagnosis:</b> <input type="checkbox"/> New Facility (not on fac. list)	<b>AIDS Diagnosis:</b> <input type="checkbox"/> New Facility (not on fac. list) <input type="checkbox"/> Same as HIV
Fac. Name/ Pvt. Provider: _____	Fac. Name/ Pvt. Provider: _____
Address: _____	Address: _____
City: _____ St: _____ Zip: _____	City: _____ St: _____ Zip: _____

<b>Facility Type:</b> <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Private Phys <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Blood Bank <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other: _____	<b>Facility Setting:</b> <input type="checkbox"/> Public <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> County <input type="checkbox"/> Private	<b>Facility Type:</b> <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Private Phys <input type="checkbox"/> Infect Dis. Clinic <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> HIV Counsel/ Test <input type="checkbox"/> STD Clinic <input type="checkbox"/> Blood Bank <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other: _____	<b>Facility Setting:</b> <input type="checkbox"/> Public <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> County <input type="checkbox"/> Private
--	---	---	---

## VIII. PERSONAL HISTORY

	Yes	No	Unk
• Sex with Male .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sex with Female .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Injected non-prescription drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Received clotting factor for hemophilia/coagulation disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, clotting factor type: _____ Date received: ___/___/___			
<b>Heterosexual Relations with any of the following:</b>			
• Heterosexual contact with an intravenous drug user .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heterosexual contact with a bisexual male .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heterosexual contact with person with hemophilia/coagulation disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heterosexual contact with transfusion recipient with documented HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heterosexual contact with transplant recipient with documented HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heterosexual contact with person with AIDS or documented HIV infection, risk not specified .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Received transfusion of blood/blood components (other than clotting factor) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, Date of First transfusion: ___/___/___ Last transfusion: ___/___/___			
• Received transplant of tissue/organs or artificial insemination in USA (primary mode of transmission).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Worked in a health care or clinical laboratory setting (primary mode of transmission).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other documented Risk: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## IX. LAB TESTS

<b>1. HIV Antibody Test at Diagnosis</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Pos</td> <td style="text-align: center;">Neg</td> <td colspan="3" style="text-align: center;">Collection Date</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">Mo.</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Yr.</td> </tr> <tr> <td>• HIV-1 IFA .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1 Western Blot .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• Rapid Test .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1 EIA .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1/2 EIA .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-2 EIA .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-2 Western Blot .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> </table>		Pos	Neg	Collection Date						Mo.	Day	Yr.	• HIV-1 IFA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1 Western Blot .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• Rapid Test .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1/2 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-2 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-2 Western Blot .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	<b>3. Immunologic Lab Tests (Earliest labs preferred, current acceptable)</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Count</td> <td style="text-align: center;">Percent</td> <td colspan="3" style="text-align: center;">Collection Date</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">Mo.</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Yr.</td> </tr> <tr> <td>CD4 at or closest to current diagnosis</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>First CD4 &lt;200L or &lt;14%</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> </table>		Count	Percent	Collection Date						Mo.	Day	Yr.	CD4 at or closest to current diagnosis	_ _	_ _	_	_	_	First CD4 <200L or <14%	_ _	_ _	_	_	_
	Pos	Neg	Collection Date																																																																												
			Mo.	Day	Yr.																																																																										
• HIV-1 IFA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1 Western Blot .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• Rapid Test .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1/2 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-2 EIA .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-2 Western Blot .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
	Count	Percent	Collection Date																																																																												
			Mo.	Day	Yr.																																																																										
CD4 at or closest to current diagnosis	_ _	_ _	_	_	_																																																																										
First CD4 <200L or <14%	_ _	_ _	_	_	_																																																																										
<b>2. HIV Detection Tests</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Pos</td> <td style="text-align: center;">Neg</td> <td colspan="3" style="text-align: center;">Collection Date</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">Mo.</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Yr.</td> </tr> <tr> <td>• HIV-1 P24 Antigen .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1 RNA PCR (Qual) .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1 Culture .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-1 Proviral DNA (Qual) .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>• HIV-2 Culture .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> </table>		Pos	Neg	Collection Date						Mo.	Day	Yr.	• HIV-1 P24 Antigen .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1 RNA PCR (Qual) .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1 Culture .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-1 Proviral DNA (Qual) .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	• HIV-2 Culture .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_	<b>4. Viral Load Tests</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Copies</td> <td style="text-align: center;">Log</td> <td colspan="3" style="text-align: center;">Collection Date</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">Mo.</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Yr.</td> </tr> <tr> <td>HIV-1 RNA NASBA</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>HIV-1 RNA RT-PCR</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>HIV-1 RNA bDNA</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> <tr> <td>HIV-1 RNA Other</td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> <td style="text-align: center;"> _ </td> </tr> </table>		Copies	Log	Collection Date						Mo.	Day	Yr.	HIV-1 RNA NASBA	_ _	_ _	_	_	_	HIV-1 RNA RT-PCR	_ _	_ _	_	_	_	HIV-1 RNA bDNA	_ _	_ _	_	_	_	HIV-1 RNA Other	_ _	_ _	_	_	_
	Pos	Neg	Collection Date																																																																												
			Mo.	Day	Yr.																																																																										
• HIV-1 P24 Antigen .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1 RNA PCR (Qual) .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1 Culture .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-1 Proviral DNA (Qual) .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
• HIV-2 Culture .....	<input type="checkbox"/>	<input type="checkbox"/>	_	_	_																																																																										
	Copies	Log	Collection Date																																																																												
			Mo.	Day	Yr.																																																																										
HIV-1 RNA NASBA	_ _	_ _	_	_	_																																																																										
HIV-1 RNA RT-PCR	_ _	_ _	_	_	_																																																																										
HIV-1 RNA bDNA	_ _	_ _	_	_	_																																																																										
HIV-1 RNA Other	_ _	_ _	_	_	_																																																																										
	<b>5. Last documented <u>Negative</u> HIV test:</b>			Mo.	Day	Yr.																																																																									
	Specify Type: _____			_	_	_																																																																									
	<b>6. If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?</b>																																																																														
	Yes	No																																																																													
	<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide date:  _   _   _																																																																												

### X. CLINICAL STATUS

Statenos: \_\_\_\_\_

Clinical Record Reviewed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asymptomatic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>AIDS INDICATOR DISEASES (O.I)</b> <small>Refer to OI table for a list of Opportunistic Infections</small>			Def	Pres	Initial Date					
					Mo.	Day	Yr.			
OI: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
OI: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
OI: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
RVCT Case Number (TB Cases) _____			If HIV tests were not done, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		

### XI. TREATMENT

<ul style="list-style-type: none"> <li>• Has this patient been informed of his/her infection ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• This patient's partners will be notified about their HIV exposure and counseled by ..... <input type="checkbox"/> Health Dept <input type="checkbox"/> Phys/Provider <input type="checkbox"/> Patient <input type="checkbox"/> Unk</li> <li>• This patient is receiving or has been referred for HIV related medical services ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unk</li> <li>• This patient is receiving or has been referred for substance abuse treatment services ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unk</li> <li>• This patient received or is receiving antiretroviral therapy (ART) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• This patient received or is receiving PCP prophylaxis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unk</li> <li>• This patient has been enrolled in a clinical trial ..... <input type="checkbox"/> NIH Spons. <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unk</li> <li>• This patient has been enrolled at a clinic ..... <input type="checkbox"/> HRSA <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unk</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <b>At time of HIV diagnosis, medical treatment was primarily reimbursed by:</b>  <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____  <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____  <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance                 </td> <td style="width: 50%; padding: 5px;"> <b>At time of AIDS diagnosis, medical treatment was primarily reimbursed by:</b>  <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____  <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____  <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance                 </td> </tr> </table>	<b>At time of HIV diagnosis, medical treatment was primarily reimbursed by:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance	<b>At time of AIDS diagnosis, medical treatment was primarily reimbursed by:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance														
<b>At time of HIV diagnosis, medical treatment was primarily reimbursed by:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance	<b>At time of AIDS diagnosis, medical treatment was primarily reimbursed by:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Public: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Private: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> No Health Insurance																
<b>For Women:</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Unk</td> </tr> <tr> <td>• Pt. is receiving / has been referred for gynecological or obstetrical services .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Is patient currently pregnant? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Has patient delivered live-born infants .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>			Yes	No	Unk	• Pt. is receiving / has been referred for gynecological or obstetrical services .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Is patient currently pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Has patient delivered live-born infants .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Unk														
• Pt. is receiving / has been referred for gynecological or obstetrical services .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
• Is patient currently pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
• Has patient delivered live-born infants .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
<b>For Children:</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%; text-align: center;">Mo.</td> <td style="width: 10%; text-align: center;">Day</td> <td style="width: 10%; text-align: center;">Yr.</td> </tr> <tr> <td>Child's Name: _____ Statenos: _____ DOB:</td> <td style="text-align: center;"><input type="text"/></td> <td style="text-align: center;"><input type="text"/></td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td colspan="4">Birth Hospital: _____ Address: _____</td> </tr> <tr> <td colspan="4">City: _____ State/Country: _____ Zip: _____</td> </tr> </table>			Mo.	Day	Yr.	Child's Name: _____ Statenos: _____ DOB:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Birth Hospital: _____ Address: _____				City: _____ State/Country: _____ Zip: _____			
	Mo.	Day	Yr.														
Child's Name: _____ Statenos: _____ DOB:	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Birth Hospital: _____ Address: _____																	
City: _____ State/Country: _____ Zip: _____																	

### XIV. LOCAL FIELDS

Prison Facility: _____
Partner's Name: _____ Partner's Statenos: _____
Previous HIV History: _____
Lab Name of First Positive Test: _____
Earliest Drug Resistance Test Laboratory: _____ Date: _____

### XV. COMMENTS

(medically relevant only) _____ _____ _____ _____
--

# HIV Testing & Treatment History (TTH) Questionnaire

Date Form Completed

Month   Day   Year



Patient Stateno:

## I. PATIENT IDENTIFICATION

Last Name:  First Name:  M.I.:

Date of Birth: Month   Day   Year

Date of Current HIV Test: Month   Day   Year

## II. FIRST POSITIVE TEST

Date of FIRST POSITIVE HIV test: (Enter date of current test if it is the first.) Month   Day   Year

Facility of Diagnosis:  City:  State:

## III. PREVIOUS HIV TESTS

Has the patient ever tested NEGATIVE for HIV? YES  NO  UNKNOWN

→ Date of LAST NEGATIVE test: Month   Year

In the 2 years before the patient's 1<sup>st</sup> positive test, how many times did the patient get tested for HIV?  
(Include the 1<sup>st</sup> positive test in the total count.)

1 (1<sup>st</sup> positive test) +  (tests before) =   (total)

## IV. ANTIRETROVIRAL MEDICATIONS

Has the patient ever taken any Antiretroviral medications (ARV)?

YES  NO  UNKNOWN

→ List Medications:

→ Start Date: Month   Day   Year

→ End Date: Month   Day   Year

Currently Taking? YES

## V. PRIMARY SOURCE OF INFORMATION (must check at least one)

If you work for STD surveillance as a DIS who interviews patients, complete section below:

DIS Patient Interview—Person conducting interview:  Date:

If you are a HARS surveillance staff member, complete section below:

Medical Chart Abstraction—Person abstracting chart:  Date:

Abstraction of DIS Interview Notes—Person abstracting notes:  Date:

## VI. ADDITIONAL SOURCE OF INFORMATION (check any that apply)

STD/MIS Abstraction—Person abstracting from STD/MIS:  Date:

Other:  Date:

## Additional Notes

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day. Isolates of organisms marked with a dagger (†) should be sent to the Texas Department of Health Laboratory.

### Positive Bacterial Cultures or Direct Examinations

Result	Reportable Disease
any bacterial agent in CSF	bacterial meningitis
<i>Bacillus anthracis</i> †	anthrax
<i>Bordetella pertussis</i>	<b>pertussis</b>
<i>Borrelia burgdorferi</i> †	Lyme disease
<i>Borrelia species</i> †	relapsing fever
<i>Brucella species</i>	brucellosis
<i>Campylobacter species</i>	campylobacteriosis
<i>Chlamydia trachomatis</i>	lymphogranuloma venereum
<i>Clostridium botulinum</i> †	<b>botulism</b>
<i>Clostridium tetani</i>	tetanus
<i>Corynebacterium diphtheriae</i> †	<b>diphtheria</b>
<i>Ehrlichia species</i>	ehrlichiosis
<i>Escherichia coli</i> O157:H7 †	<i>E. coli</i> O157:H7 infection
<i>Haemophilus ducreyi</i>	chancroid
<i>Haemophilus influenzae</i> type b (not from throat, sputum)	<b><i>H. influenzae</i> type b infection, invasive</b>
<i>Legionella species</i> †	legionellosis
<i>Listeria monocytogenes</i> †	listeriosis
<i>Mycobacterium tuberculosis</i> †	tuberculosis *
<i>Neisseria gonorrhoea</i>	gonorrhoea
<i>Neisseria meningitidis</i> † (not from throat, sputum)	<b>meningococcal infection, invasive</b>
<i>Rickettsia</i> species within the spotted fever group	spotted fever group rickettsioses
<i>Rickettsia</i> species within the typhus group	typhus
<i>Salmonella species</i> , not <i>S. typhi</i>	salmonellosis
<i>Salmonella typhi</i> †	typhoid fever
<i>Shigella species</i>	shigellosis
<i>Streptococcus species</i> . (not from throat, sputum)	Streptococcus infection, invasive
<i>Vibrio cholerae</i> O1†	<b>cholera</b>
<i>Vibrio species</i> †	<i>Vibrio</i> infection
<i>Yersinia enterocolitica</i>	yersiniosis
<i>Yersinia pseudotuberculosis</i>	yersiniosis
<i>Yersinia pestis</i> †	<b>plague</b>

Contact the Texas Department of Health Laboratory at (512) 458-7581  
for appropriate tests when considering a diagnosis of botulism.

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone.

### Positive Viral Cultures or Direct Examinations

Result	Reportable Disease Condition
any virus in CSF	aseptic meningitis or encephalitis
California group virus	California encephalitis or encephalitis due to virus within California group
dengue virus, type 1,2,3, or 4	dengue
Eastern equine encephalomyelitis virus	Eastern equine encephalitis
enteroviruses (only if patient has aseptic meningitis or encephalitis)	
poliovirus, type 1,2, or 3	<b>poliomyelitis</b>
St. Louis encephalitis virus	St. Louis encephalitis
Venezuelan equine encephalomyelitis virus	Venezuelan equine encephalitis
Western equine encephalomyelitis virus	Western equine encephalitis
yellow fever virus	<b>yellow fever</b>

**Contact the Texas Department of Health at (512) 458-7676 for appropriate tests when considering a diagnosis of hantavirus infection, rabies, or viral hemorrhagic fever.**

### Positive Fungal Cultures or Direct Examinations

Result	Reportable Disease Condition
any fungus in CSF	fungal meningitis

### Positive Parasitic Cultures or Direct Examinations

Result	Reportable Disease Condition
any parasite in CSF †	parasitic meningitis
<i>Entamoeba histolytica</i>	amebiasis
<i>Plasmodium species</i> †	malaria
<i>Cryptosporidium parvum</i>	cryptosporidiosis

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day. Confirmatory tests for most of these diseases are available through the Texas Department of Health.

### Positive Serologic Tests For:

amebiasis  
brucellosis  
California encephalitis  
chickenpox  
cholera  
dengue  
Eastern equine encephalitis  
ehrlichiosis  
hantavirus  
hepatitis A (anti-HAV IgM)<sup>1</sup>  
hepatitis B (anti-HBc IgM)<sup>1</sup>  
hepatitis C (anti-HCV)<sup>1</sup>  
hepatitis D (anti-HDV, HbsAg)<sup>1</sup>  
hepatitis E (anti-HEV)<sup>1</sup>  
HIV infection  
legionellosis<sup>2</sup>  
Lyme disease  
lymphogranuloma venereum  
malaria  
**measles**  
mumps  
**plague**  
**poliomyelitis**  
relapsing fever  
spotted fever group rickettsioses (such as Rocky Mountain spotted fever)  
rubella\*  
St. Louis encephalitis  
syphilis  
typhus group rickettsioses (such as flea- or louse-borne typhus)  
Venezuelan equine encephalitis  
Western equine encephalitis  
**yellow fever**

<sup>1</sup> Refer positive results for hepatitis to infection control practitioner who will determine whether they are reportable.

<sup>2</sup> Serologic confirmation of an acute case of legionellosis can not be based on a single titer. There must be a four-fold rise in titer to  $\geq 1:128$  between acute and convalescent specimens.

## ICD-9 Codes That Must be Reported to the Local Health Authority

When any of the following ICD-9 codes are listed in a patient's discharge summary, a report shall be made to the local health authority (local health department) via the reporting officer for the hospital. Reports shall be made at least **WEEKLY**. Diseases marked with an asterisk (\*) shall be reported immediately by telephone. Diseases marked with a double asterisk (\*\*) shall be reported within one working day.

ICD-9 Code(s)	Disease/Condition
001	Cholera *
002.0	Typhoid fever
003	Salmonellosis
004	Shigellosis
005.1	Food poisoning due to <i>C. botulinum</i> *
005.4	Food poisoning due to <i>V. parahaemolyticus</i>
006	Amebiasis
008.04	<i>E. coli</i> O157:H7 infection
008.43	Campylobacteriosis
010 - 018	Tuberculosis**
020	Plague *
022	Anthrax
023	Brucellosis
027.0	Listeriosis
027.8	Yersiniosis
030	Leprosy (Hansen's disease)
032	Diphtheria *
033	Pertussis *
036	Meningococcal infections, invasive *
037	Tetanus
038.0	Streptococcal septicemia
038.2	Pneumococcal septicemia
040.8	Botulism, infant
041.0	Streptococcal disease (invasive)
041.5	<i>H. influenzae</i> infection, invasive *
042-044	HIV infection
045	Poliomyelitis, paralytic *
046.1	Creutzfeldt-Jakob disease
047	Meningitis due to enterovirus
049	Viral encephalitis
052	Chickenpox (by age group & number)
055	Measles *
056	Rubella **
060	Yellow fever *
061	Dengue
062	Mosquito-borne viral encephalitis
063	Tick-borne viral encephalitis
064	Viral encephalitis by unknown vector
065	Arthropod-borne hemorrhagic fever
066.2	Venezuelan equine encephalitis
070	Viral hepatitis (acute)
071	Rabies *
072	Mumps
078.6	Hemorrhagic nephrosonephritis
078.7	Arenaviral hemorrhagic fever
078.89	Ebola-Marburg viral diseases

ICD-9 Code(s)	Disease/Condition
080	Typhus, epidemic
081.0	Typhus, murine
082	Tick-borne rickettsioses
083.2	Rickettsial pox
083.8	Ehrlichiosis
084	Malaria
087	Relapsing fever
088.81	Lyme disease
090	Congenital syphilis
091-097	Syphilis
098	Gonococcal infections
099.0	Chancroid
099.1	Lymphogranuloma venereum
099.5	Venereal diseases caused by <i>C. trachomatis</i>
100.81	Leptospiral meningitis
104.8	Lyme disease
124	Trichinosis
130.0	Meningoencephalitis due to toxoplasmosis
136.2	Meningoencephalitis due to <i>Naegleria</i>
136.8	Cryptosporidiosis
283.11	Hemolytic uremic syndrome
290.1	Dementia in Creutzfeldt-Jakob disease
320.0	Meningitis due to <i>H.influenzae</i> *
320.1 - 320.9	Bacterial meningitis
321	Meningitis
323	Viral encephalitis
480.8	Hantavirus pulmonary syndrome
481	Pneumococcal pneumonia
482.8	Legionellosis
482.30 - 482.39	Pneumonia due to <i>Streptococcus</i>
501	Asbestosis
502	Silicosis
692.3	Occupational pesticide poisoning (adults)
692.4	Occupational pesticide poisoning (adults)
729.4	Fasciitis due to <i>Streptococcus</i>
771.0	Congenital rubella syndrome **
771.2	Congenital listeriosis, malaria, tuberculosis**
790.7	Bacteremia due <i>Streptococcus</i>
806	Spinal cord injuries
952	Spinal cord injuries
984	Lead poisoning
989.2-989.4	Occupational pesticide poisoning (adults)
994.1	Drowning

## Laboratory Results That Must be Reported to the Local Health Authority

Hospital laboratories shall report these laboratory findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day

### Positive Blood Chemistries

blood lead levels of  $\geq 10$   $\mu\text{g/dL}$  in children  
blood lead levels of  $\geq 25$   $\mu\text{g/dL}$  in adults  
pesticide poisoning in adults

### Surgical Pathology Results

asbestosis  
silicosis  
Hansen's disease  
tuberculosis \*  
**human rabies**  
Creutzfeldt-Jakob disease

## Laboratory Results That Must be Reported Directly to the Texas Department of Health

Laboratories shall report these findings to the Infectious Disease Epidemiology and Surveillance Division, Texas Department of Health. Isolates in **bold type** shall be reported **immediately** by calling **(800)252-8239**; in addition, isolates in **bold type** should be sent to the Texas Department of Health Laboratory. Reports of the other resistant organisms listed below may be faxed to (512) 458-7616 no later than the last working day of March, June, September, and December. All reports should include patient name, date of birth or age, sex, anatomic site of culture, and city of submitter.

Penicillin-resistant *Streptococcus pneumoniae*.  
Vancomycin resistant *Enterococcus*,  
**Vancomycin resistant *Staphylococcus aureus***  
**Vancomycin resistant coagulase negative *Staphylococcus* species**

**In addition**, laboratories shall report the following findings, **by numeric totals**, no later than the last working day of March, June, September, and December:

All isolates of *Enterococcus* species  
All isolates of *Streptococcus pneumoniae*.



## **IMPORTANT NOTICE**

**Effective March 1, 2007**, the following bacterial isolates or specimens shall be submitted to the Texas Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, TX 78756-3199.

***Bacillus anthracis***

***Brucella species***

***Clostridium botulinum* – adult and infant**

***Escherichia coli* O157:H7 or any specimen demonstrating Shiga toxin activity**

***Francisella tularensis***

***Listeria monocytogenes***

***Neisseria meningitidis* - from normally sterile sites**

***Staphylococcus aureus* with vancomycin-resistance (MIC greater than 2 µg/ml) (VISA/VRSA)**

***Vibrio species***

***Yersinia pestis***

Isolates and specimens shall be submitted using a current department Specimen Submission Form (G-2B).

For more information, go to [www.dshs.state.tx.us/lab](http://www.dshs.state.tx.us/lab). Under the “Guidelines for Collecting & Handling Specific Types of Specimens”, click on “Bacteriology Collection, Transport and Storage Guidelines”. Laboratory Services Section telephone number: 512-458-7318 or 888-963-7111 ext. 7318 FAX number: 512-458-7294

# Communicable Disease Control

*These sections are adopted from the Texas Administrative Code, Chapter 97. The provisions for this chapter are issued under the Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81, which provides the Board of Health with the authority to adopt rules concerning the reporting of communicable diseases; and §12.001, which provides the Texas Board of Health with the authority to adopt rules for the performance of every duty imposed by law on the Texas Board of Health, the Texas Department of Health, and the Commissioner of Health.*

## **RULE §97.2    Who Shall Report**

- A. A physician, dentist, veterinarian, chiropractor, advanced practice nurse, physician assistant, or person permitted by law to attend a pregnant woman during gestation or at the delivery of an infant shall report, as required by these sections, each patient (person or animal) he or she shall examine and who has or is suspected of having any notifiable condition, and shall report any outbreak, exotic disease, or unusual group expression of illness of any kind whether or not the disease is known to be communicable or reportable. An employee from the clinic or office staff may be designated to serve as the reporting officer. A physician, dentist, veterinarian, or chiropractor who can assure that a designated or appointed person from the clinic or office is regularly reporting every occurrence of these disease or health conditions in their clinic or office does not have to submit a duplicate report.
- B. The chief administrative officer of a hospital shall appoint one reporting officer who shall be responsible for reporting each patient who is medically attended at the facility and who has or is suspected of having any notifiable condition. Hospital laboratories may report through the reporting officer or independently in accordance with the hospital's policies and procedures.
- C. Except as provided in subsection (b) of this section, any person who is in charge of a clinical laboratory, blood bank, mobile unit, or other facility in which a laboratory examination of any specimen derived from a human body yields microscopic, bacteriologic, virologic, parasitologic, serologic, or other evidence of a notifiable condition, shall report as required by this section.
- D. School authorities, including a superintendent, principal, teacher, school health official, or counselor of a public or private school and the administrator or health official of a public or private institution of higher learning should report as required by these sections those students attending school who are suspected of having a notifiable condition. School administrators who are not medical directors meeting the criteria described in §97.132 of this title (relating to Who

Shall Report Sexually Transmitted Diseases) are exempt from reporting sexually transmitted diseases.

- E. Any person having knowledge that a person or animal is suspected of having a notifiable condition should notify the local health authority or the department and provide all information known to them concerning the illness and physical condition of such person or persons.
- F. Sexually transmitted diseases including HIV and AIDS shall be reported in accordance with §97.132 of this title.
- G. Failure to report a notifiable condition is a Class B misdemeanor under the Texas Health and Safety Code, §81.049.

**\*Source note:** The provisions of the §97.2 adopted to be effective March 16, 1994, 19TexReg 1453; amended to be effective March 5, 1998, 23 TexReg 1954; amended to be effective January 1, 1999, 23 TexReg 12663; amended to be effective March 26, 2000, 25 TexReg 2343; amended to be effective December 20, 2000, 25 TexReg 12426; amended to be effective August 5, 2001, 26 TexReg 5658.



Austin/Travis County Health & Human Services Department

DIVISION OF THE MEDICAL DIRECTOR  
EPIDEMIOLOGY AND DISEASE SURVEILLANCE UNIT  
15 Waller Street, 4<sup>th</sup> Floor  
Austin, TX 78702



May 11, 2011

To Whom It May Concern:

We understand that there may be some confusion regarding HIPAA and release of protected health information to public health authorities. Therefore, we would like to provide this letter to help clarify the relationship between HIPAA and public health functions. The Epidemiology and Disease Surveillance Unit's Disease Surveillance Program is an agency of the City of Austin and is conducting the activity described here in its capacity as a public health authority as defined by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information; Final Rule (Privacy Rule)[45 CFR 164.501].

**Pursuant to 45 CFR 164.512(b) of the Privacy Rule, covered entities such as your organization may disclose, without individual authorization, protected health information to public health authorities "... authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions..."**

The Disease Surveillance Program is conducting disease surveillance and reporting, a public health activity as described by 45 CFR 164.512(b), and is authorized by law. The information being requested represents the minimum necessary to carry out the public health purposes of this project pursuant to 45 CFR 164.514(d) of the Privacy Rule.

If you have any questions or concerns, please contact me at (512) 972-5487; I am the HIPAA privacy officer for our program. Enclosed for your use is a reporting form specific to the disease for which the Disease Surveillance Program is requesting information. Thank you for your cooperation in our endeavors to provide service.

Kindest Regards,

A handwritten signature in cursive script that reads "Ella d. Puga".

Ella d. Puga, MPH  
Unit Privacy Officer  
Epidemiology and Disease Surveillance Unit



## Austin/Travis County Health and Human Services Department

Communicable Disease Surveillance Program  
15 Waller Street  
Austin, Texas 78702



### WEBSITES Related to Disease Reporting

#### Infectious Diseases & Surveillance

[www.dshs.state.tx.us](http://www.dshs.state.tx.us) – Texas Department of State Health Services

- Latest News and updates
- Links to disease reporting

[www.dshs.state.tx.us/idcu](http://www.dshs.state.tx.us/idcu) – Infectious Disease Epidemiology & Surveillance

- Notifiable conditions with reporting instructions
- Case definitions, Center for Disease Control and Prevention
- Infectious Disease Topics
- Related Rules and Regulations
- Blood lead reporting
- HIV and STD reporting
- TB reporting
- Contaminated Sharps Injury Reporting
- Links to community preparedness, immunizations and laboratory services
- Communicable Disease Chart for Schools and Childcare Centers
  - Criteria for exclusion and readmission to schools and daycare in Texas

#### Vaccine Preventable Diseases

[www.dshs.state.tx.us/immunize](http://www.dshs.state.tx.us/immunize)

- Information for parents and providers
- Immunization schedules
- ImmTrac - Texas
- Surveillance guidelines and forms
- Statistics

#### Local Services

[www.ci.austin.tx.us](http://www.ci.austin.tx.us) – Austin City Connection Home Page. Click on **HEALTH** link.

- Public health and community sources
  - Environmental and Consumer Health
  - Restaurant inspection scores
  - Public Health Emergency Preparedness and Response
- Health and Human Services
- Animal Services
- Community Health Centers
  - Locations
  - Eligibility
  - Homeless health services
- Medical Assistance Program
- Austin Women's Hospital