



DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
ADULT HIV CONFIDENTIAL CASE REPORT FORM
(Clients ≥13 years of age at time of diagnosis)

I. Health Department Use Only
1. Date Rec'd at Health Department:
2. Document Source:
3. State No.:
4. Did this report initiate a new case investigation?
5. Report Medium
6. Surveillance Method
*Patient identifier information NOT transmitted to CDC

II. Facility Providing Information
7. Date Form Completed:
*8. Medical Record Number:
*9. Person Completing Form:
*10. Phone Number:
11. Facility Name:
12. Facility ID:
*13. Phone:
*14. Street Address:
15. City:
16. County/*Ward:
17. State/Country:
*18. ZIP Code:
19. Facility Type (refer to reference page 5):

III. Client Identification
*Client Name:
20. First Name
21. Middle Name
22. Last Name
*Alternate Name:
23. First Name
24. Middle Name
25. Last Name
*26. Phone
27. Address Type:
*28. Current Street Address
29. City
30. County/*Ward
31. State/Country
*32. ZIP Code
*33. Social Security Number
*34. Other ID (please specify):
*34a. Other ID Number:

IV. Client Demographics
35. Diagnosis Status:
36. Sex assigned at birth:
37. Date of Birth:
38. Alias Date of Birth:
39. Country of Birth:
40. Vital Status:
41. Date of Death
42. State of Death
43. Current Gender Identity:
44. Marital Status:
45. Education:
46. Ethnicity
*47. Expanded Ethnicity
48. Race
*49. Expanded Race

V. Residence at Diagnosis (add additional addresses in Comments)
50. Address Type:
51. Street Address:
52. City:
53. County/*Ward:
54. State/Country:
*55. ZIP Code:

VI. Facility of Diagnosis
56. Diagnosis Type (check all that apply)
57. Facility Name:
*58. Phone:
*59. Street Address:
60. City:
61. County/*Ward:
62. State/Country:
*63. ZIP Code:
64. Facility Type (refer to reference page 5):
*65. Provider Name:
*66. Provider Phone:
*67. Specialty:

Client name:

VII. Client History (respond to all questions) 68. Pediatric risk (please enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, the client had...

<p>69. Vaginal sex with female <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 69a - 69f about your partner(s) If No or Unknown, go to 70.</p>	<p>69a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>69b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>69c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>69d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>69e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>69f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>70. Anal sex with female <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 70a - 70f about your partner(s) If No or Unknown, go to 71.</p>	<p>70a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>70b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>70c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>70d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>70e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>70f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>71. Anal sex with male <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 71a - 71f about your partner(s) If No or Unknown, go to 72.</p>	<p>71a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>71b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>71c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>71d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>71e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>71f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>72. Vaginal sex with a transgendered individual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 72a - 72f about your partner(s) If No or Unknown, go to 73.</p>	<p>72a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>72d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>73. Anal sex with a transgendered individual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 73a - 73f about your partner(s) If No or Unknown, go to 74.</p>	<p>73a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>73d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

FEMALE CLIENTS ONLY:

<p>74. Vaginal sex with male <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 74a - 74f about your partner(s) If No or Unknown, go to 75.</p>	<p>74a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>74d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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75. Vaginal sex with an MSM Yes No Unknown **76. Anal sex with an MSM** Yes No Unknown

OTHER: (ALL CLIENTS)

77. Used injected non-prescription drugs Yes No Unknown **77a. If yes, did the client share drug injection equipment?** Yes No Unknown

78. Received clotting factor for hemophilia/coagulation disorder Yes No Unknown

78a. If yes, specify the clotting factor: _____ **78b. If yes, date received:** _____

79. Received transfusion of blood/blood components (other than clotting factor) Yes No Unknown (document reason in Comments section)

79a. If yes, first date received: _____ **79b. If yes, last date received:** _____

80. Received transplant of tissue/organs or artificial insemination Yes No Unknown

81. Worked in a healthcare or clinical laboratory setting Yes No Unknown

81a. If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____

82. Other documented risk: (please include detail in Comments section) Yes No Unknown

HEALTH DEPARTMENT USE ONLY

83. Is this an NIR/NRR case? Yes No Unknown **83a. If No Risk Reported, indicate date investigation was complete:** _____

Client name:

VIII. Treatment/Services Referrals

84. Has this client been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
85. This client's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health Dept <input type="checkbox"/> Physician/Provider <input type="checkbox"/> Client <input type="checkbox"/> Unknown	
86. Was client linked to HIV medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	87. Was the client referred to/contacted by DC DOH Partner Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
86a. If no, why? <input type="checkbox"/> Client already in HIV care <input type="checkbox"/> Client declined HIV care	87a. If yes, was the client interviewed by DC DOH Partner Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
86b. If yes, did client attend the first appointment? <input type="checkbox"/> Confirmed- Accessed service <input type="checkbox"/> Confirmed- Did not access service <input type="checkbox"/> Don't Know <input type="checkbox"/> Pending <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> No follow-up	87b. If yes, was the client interview within 30 days of receiving their result? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
86c. If yes, was the first appointment within 90 days of the HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
88. Was the client referred to DC DOH HIV Prevention Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
88a. If yes, did the client receive DC DOH HIV Prevention Services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
89. The client is receiving/received or has been referred for: <input type="checkbox"/> Substance abuse treatment services <input type="checkbox"/> PCP prophylaxis	
90. This patient has been enrolled at: <input type="checkbox"/> Clinical Trial (specify in comment section) <input type="checkbox"/> Clinic (specify in comment section)	
91. At time of HIV diagnosis, medical treatment primarily reimbursed by (See reference sheet on page 5):	92. At time of AIDS diagnosis, medical treatment primarily reimbursed by (See reference sheet on page 5):
93. Is the client receiving any of the following treatment reimbursements? <input type="checkbox"/> ADAP <input type="checkbox"/> Alliance <input type="checkbox"/> Medicare	
94. Is the client's partner(s) pregnant? <input type="checkbox"/> Yes, confirmed <input type="checkbox"/> Yes, unconfirmed <input type="checkbox"/> No <input type="checkbox"/> Unknown	
95. Number of the client's sex or needle sharing partners in the past 12 months? _____	
95a. Number of those partners for whom you collected contacting information (address, phone number, email address, screen name) _____	

For Female Client

96. This client is receiving or been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	97. Has this client delivered a live-born infant(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
98. Is this client pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	98a. If yes, is client in prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked

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

*99. Child's Name	100. Child's Date of Birth	
*101. Child's Coded ID	102. Child's State No.	
103. Hospital of Birth Name	*104. Phone	*105. ZIP Code

Co-infections

106. Acute Hepatitis B Dx Date:	107. Chronic Hepatitis B Dx Date:
108. Acute Hepatitis C Dx Date:	109. Chronic Hepatitis C Dx Date:
110. Name of STD1:	110a. Date of Dx STD1:
111. Name of STD2:	111a. Date of Dx STD2:
112. Name of STD3:	112a. Date of Dx STD3:

IX. HIV Testing and Antiretroviral Use History

113. Main Source of Testing and Treatment History Information (select one): <input type="checkbox"/> Client Interview <input type="checkbox"/> Medical Records Review <input type="checkbox"/> Provider Report <input type="checkbox"/> PEMS <input type="checkbox"/> Other	114. Date Client Reported Information
115. Ever had previous positive HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ Unknown <input type="checkbox"/> Declined	116. Date of First Positive HIV test
117. Ever tested HIV negative? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ Unknown <input type="checkbox"/> Declined	118. Date of Last Negative HIV test (if date is from a lab test with test type, enter in Lab Data section)
119. Number of negative HIV tests within 24 months before the current (or first positive) HIV test: # Or <input type="checkbox"/> Don't know/ Unknown <input type="checkbox"/> Declined	
120. Ever taken any antiretroviral (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ Unknown <input type="checkbox"/> Declined	
120a. If Yes, list ARV Medications (refer to reference page 5):	
121. Date First Began:	122. Date of Last Use:

***X. Provider Comments**

123.

Client name: _____

XI. Laboratory Data (record additional tests in Comments section)

HIV Antibody Tests at Diagnosis (non-type differentiating)

Test 1 124. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 125. Result: Positive/Reactive Negative/Nonreactive Indeterminate 126. Rapid Test (check if rapid)
 127. Collection Date: _____ 128. Accession #: _____ 129. Manufacturer: _____

Test 2 130. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 131. Result: Positive/Reactive Negative/Nonreactive Indeterminate 132. Rapid Test (check if rapid)
 133. Collection Date: _____ 134. Accession #: _____ 135. Manufacturer: _____

Test 3 136. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 137. Result: Positive/Reactive Negative/Nonreactive Indeterminate 138. Rapid Test (check if rapid)
 139. Collection Date: _____ 140. Accession #: _____ 141. Manufacturer: _____

HIV Antibody Tests at Diagnosis (type differentiating)

Test 142. Type: HIV-1/2 Differentiating (e.g., Multispot)
 143. Result: HIV-1 HIV-2 Both (undifferentiated) Neither (negative) Indeterminate
 144. Collection Date: _____ 145. Accession #: _____

HIV Antibody Detection Tests

Test 1 146. Type: HIV-1 p24 Antigen HIV-1 RNA/DNA NAAT (Qual) HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture
 147. Result: Positive/Reactive Negative/Nonreactive Indeterminate 148. Collection date: _____ 149. Accession #: _____

Test 2 150. Type: HIV-1 p24 Antigen HIV-1 RNA/DNA NAAT (Qual) HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture
 151. Result: Positive/Reactive Negative/Nonreactive Indeterminate 152. Collection date: _____ 153. Accession #: _____

Immunologic Lab Tests

At or closest to current diagnosis status: First <200 µL or <14%:
 154. CD4 count _____ cells/µL 158. CD4 count _____ cells/µL
 155. CD4 count _____ % 159. CD4 count _____ %
 156. Collection Date: _____ 160. Collection Date: _____
 157. Accession #: _____ 161. Accession #: _____

Viral Load Tests (include earliest detectable test after diagnosis)

Test 1 162. Result 163. Copies/ µL _____ 165. Collection Date: _____
 HIV-1 Detectable 164. Log _____ 166. Accession #: _____
 RNA VL Undetectable
 Test 2 167. Result 168. Copies/ µL _____ 170. Collection Date: _____
 HIV-1 Detectable 169. Log _____ 171. Accession #: _____
 RNA VL Undetectable

172. Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? Yes No Unknown

172a. If YES, provide date (specimen collection date if known) of earliest positive test for this algorithm: _____

173. If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes No Unknown

173a. If YES, provide date of documentation by Physician: _____

174. Date of last documented negative HIV test: _____ 174a. Specify Type of test: _____

175. Genotyping Date: _____ 176. Phenotyping Date: _____

XII. Clinical (select D for Definitive or P for Presumptive where applicable)

177. Clinical Record Reviewed		178. The client was diagnosed as:		178a. Date the client was diagnosed with one of the previous options						
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic (not AIDS)		(If Symptomatic, indicate the following diagnosis's of client)						
	D	P	Date	D	P	Date	D	P	Date	
179. Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/>			<input type="checkbox"/>			197. M. tuberculosis, pulmonary*	<input type="checkbox"/>		
180. Candidiasis, esophageal	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			198. M. tuberculosis, disseminated or extrapulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	
181. Carcinoma, invasive cervical	<input type="checkbox"/>			<input type="checkbox"/>			199. Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
182. Coccidiomycosis, disseminated or extrapulmonary	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		200. Pneumocystis carinii pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
183. Cryptococcosis, extrapulmonary	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		201. Pneumonia, recurrent, in 12 mo. period	<input type="checkbox"/>	<input type="checkbox"/>	
184. Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>			<input type="checkbox"/>			202. Progressive multifocal leukoencephalopathy	<input type="checkbox"/>		
185. Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/>			<input type="checkbox"/>			203. Salmonella septicemia, recurrent	<input type="checkbox"/>		
186. Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			204. Toxoplasmosis of brain, onset at >1 mo. of age	<input type="checkbox"/>	<input type="checkbox"/>	
187. HIV encephalopathy	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		205. Wasting syndrome due to HIV	<input type="checkbox"/>		
188. Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis										
189. Histoplasmosis, disseminated or extrapulmonary										
190. Isosporiasis, chronic intestinal (>1 mo. duration)										
191. Kaposi's sarcoma										
192. Lymphoid interstitial pneumonia and/or pulmonary lymphoid										
193. Lymphoma, Burkitt's (or equivalent)										
194. Lymphoma, immunoblastic (or equivalent)										
195. Lymphoma, primary in brain										
196. Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary										

*206. If TB selected above, indicate RVCT Case Number: _____



**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
ADULT HIV CONFIDENTIAL CASE REPORT FORM**

Reference Page

Question	Options					
19. and 64. Facility Type	Inpatient: <ul style="list-style-type: none"> • Hospital • Other, specify 	Outpatient: <ul style="list-style-type: none"> • Private Physician Office • Adult HIV Clinic • Other, specify 	Screening, Diagnostic, Referral Agency: <ul style="list-style-type: none"> • CTS • STD Clinic • Other, specify 	Other Facility: <ul style="list-style-type: none"> • Emergency Room • Laboratory • Corrections • Unknown • Other, specify 		
91. At time of HIV diagnosis, medical treatment primarily reimbursed by:	<ul style="list-style-type: none"> • CHAMPUS/TRICARE • Children’s Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO 	<ul style="list-style-type: none"> • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other 	<ul style="list-style-type: none"> • State Funded, Unspecified • Veterans Administration • No Health Insurance • Other • Unknown 			
92. At time of AIDS diagnosis, medical treatment primarily reimbursed by:	<ul style="list-style-type: none"> • CHAMPUS/TRICARE • Children’s Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO 	<ul style="list-style-type: none"> • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other 	<ul style="list-style-type: none"> • State Funded, Unspecified • Veterans Administration • No Health Insurance • Other • Unknown 			
120a. If Yes, list ARV Medications:	<table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 50%;"> <ul style="list-style-type: none"> • Agenerase (amprenavir) • Aptivus (tipranavir,TPV) • Atripla (efavirenz/emtricitabine/tenofovir DF) • Combivir (lamivudine/zidovudine, 3TC/AZT) • Complera (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TDF) • Crixivan (indinavir, IDV) • Edurant (rilpivirine, RPV) • Emtriva (emtricitabine, FTC) • Epivir (lamivudine, 3TC) • Epzicom (abacavir/lamivudine, ABD/3TC) • Fortovase (saquinavir, SQV) • Fuzeon (enfuvirtide, T20) • Hepsera (adefovir) • Hivid (zalcitabine, ddC) • Hydroxyurea • Intelence (etravirine) • Invirase (saquinavir, SQV) • Isentress (raltegravir) • Kaletra (lopinavir, ritonavir) • Lexiva (fosamprenavir, 908) </td> <td style="vertical-align: top; width: 50%;"> <ul style="list-style-type: none"> • Norvir (ritonavir, RTV) • Prezista (darunavir, DRV) • Rescriptor (delavirdine, DLV) • Retrovir (zidovudine, ZDV, AZT) • Reyataz (atazanavir, ATV) • Saquinavir (fortavase, invirase) • Selzentry (maraviroc) • Sustiva (efavirenz, EFV) • Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) • Truvada (tenofovir DF/emtricitabine, TDF/FTC) • Videx (didanosine, ddl) • Videx EC (didanosine, ddl) • Viracept (nelfinavir, NFV) • Viramune (nevirapine, NVP) • Viread (tenofovir DF, TDF) • Zerit (stavudine, d4T) • Ziagen (abacavir, ABC) • Other • Unspecified </td> </tr> </table>				<ul style="list-style-type: none"> • Agenerase (amprenavir) • Aptivus (tipranavir,TPV) • Atripla (efavirenz/emtricitabine/tenofovir DF) • Combivir (lamivudine/zidovudine, 3TC/AZT) • Complera (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TDF) • Crixivan (indinavir, IDV) • Edurant (rilpivirine, RPV) • Emtriva (emtricitabine, FTC) • Epivir (lamivudine, 3TC) • Epzicom (abacavir/lamivudine, ABD/3TC) • Fortovase (saquinavir, SQV) • Fuzeon (enfuvirtide, T20) • Hepsera (adefovir) • Hivid (zalcitabine, ddC) • Hydroxyurea • Intelence (etravirine) • Invirase (saquinavir, SQV) • Isentress (raltegravir) • Kaletra (lopinavir, ritonavir) • Lexiva (fosamprenavir, 908) 	<ul style="list-style-type: none"> • Norvir (ritonavir, RTV) • Prezista (darunavir, DRV) • Rescriptor (delavirdine, DLV) • Retrovir (zidovudine, ZDV, AZT) • Reyataz (atazanavir, ATV) • Saquinavir (fortavase, invirase) • Selzentry (maraviroc) • Sustiva (efavirenz, EFV) • Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) • Truvada (tenofovir DF/emtricitabine, TDF/FTC) • Videx (didanosine, ddl) • Videx EC (didanosine, ddl) • Viracept (nelfinavir, NFV) • Viramune (nevirapine, NVP) • Viread (tenofovir DF, TDF) • Zerit (stavudine, d4T) • Ziagen (abacavir, ABC) • Other • Unspecified
<ul style="list-style-type: none"> • Agenerase (amprenavir) • Aptivus (tipranavir,TPV) • Atripla (efavirenz/emtricitabine/tenofovir DF) • Combivir (lamivudine/zidovudine, 3TC/AZT) • Complera (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TDF) • Crixivan (indinavir, IDV) • Edurant (rilpivirine, RPV) • Emtriva (emtricitabine, FTC) • Epivir (lamivudine, 3TC) • Epzicom (abacavir/lamivudine, ABD/3TC) • Fortovase (saquinavir, SQV) • Fuzeon (enfuvirtide, T20) • Hepsera (adefovir) • Hivid (zalcitabine, ddC) • Hydroxyurea • Intelence (etravirine) • Invirase (saquinavir, SQV) • Isentress (raltegravir) • Kaletra (lopinavir, ritonavir) • Lexiva (fosamprenavir, 908) 	<ul style="list-style-type: none"> • Norvir (ritonavir, RTV) • Prezista (darunavir, DRV) • Rescriptor (delavirdine, DLV) • Retrovir (zidovudine, ZDV, AZT) • Reyataz (atazanavir, ATV) • Saquinavir (fortavase, invirase) • Selzentry (maraviroc) • Sustiva (efavirenz, EFV) • Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) • Truvada (tenofovir DF/emtricitabine, TDF/FTC) • Videx (didanosine, ddl) • Videx EC (didanosine, ddl) • Viracept (nelfinavir, NFV) • Viramune (nevirapine, NVP) • Viread (tenofovir DF, TDF) • Zerit (stavudine, d4T) • Ziagen (abacavir, ABC) • Other • Unspecified 					

Please print a completed copy, place into a double-sealed envelope, marked “CONFIDENTIAL,” and mail or hand deliver to the address provided at the bottom of this page. You may also contact the DOH Field Investigator assigned to your site from the HIV/AIDS, Hepatitis, STD and TB Administration to retrieve the completed documents. The Field Investigator may review the documents for completeness and accuracy against the patient’s medical charts. Any deficiencies will require the Field Investigator to obtain missing or discrepant information via telephone, in-person interview, chart abstraction or other methods deemed appropriate. It is not acceptable to FAX or e-mail a form with client information on it. Chapter 22 of The District of Columbia Municipal Regulations contains information on the reporting requirements for communicable diseases with a specific section for HIV. All Human Immunodeficiency Virus (HIV) infection cases (including Acquired Immune Deficiency Syndrome (AIDS)) shall be reported to the Director of the Department of Health or his or her designee. Physicians and others licensed to practice in the District under the District of Columbia Health Occupations Revision Act of 1985 (D.C. Official Code § 3-1201.01 et seq.), in charge of an AIDS diagnosis, shall report the AIDS diagnosis to the Director within forty-eight (48) hours of diagnosis and furnish information the Director deems necessary to complete a confidential case report. Additionally, physicians and others licensed under the District of Columbia Health Occupations Revision Act of 1985 shall report a HIV positive test result to the Director or his or her designee. The physician or provider, laboratory, blood bank, or other entity or facility that provides HIV testing shall report all cases of HIV infection to the Director or his or her designee.

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