Mission:

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.



Joseph A. Ladapo, MD, PhD

State Surgeon General

Vision: To be the Healthiest State in the Nation

Attached is the most current CDC case report for reporting confirmed HIV positive testing (Rev. 01/2023).

Please complete and submit (with copies all the associated HIV labs) for any patient that test HIV positive in any of the following counties Alachua, Bradford, Columbia, Citrus, Dixie, Gilchrist, Hamilton, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, or Union Counties of Florida.

It matters not where they reside at time of testing reporting is based on the county that the provider is in.

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Mailing address:

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I. Patient	l Identificati	on (re	cord all date			ууу)		*Last Name			Lá	ast Name Soundex	
										Zust Humo Goundox			
Alternate Name Type (ex: Alias, Married)				*	*First Name			*Middle Name		,	*Last Name		
Address Ty	/pe □ Residentia					*Curr	ent Addre	ss, Street				Address Date	
			omeless □ Mili □ Temporary	tary [□ Other							1 1	
*Phone	2 : 33	City			County			State/Country			*Z	IP Code	_
*Medical R	ecord Number					*Other ID	Type S	SN		*Num	ber		
and Hu	Departmen	t Use	(Patients <u>></u> 13 Only (record	years d all	of age at t dates as	time of diag mm/dd/y	gnosis) *I yyyy)	ase Repor	ransmitt	ed to CD0	ved OM	Centers for Disease Contrand Prevention (CDC) B no. 0920-0573 Exp. 02/28/20	
	ved at Health D	epartme	ent		eHARS D	ocument	UID			State N	umber		
	Health Dept—Ci	ity/Cour	nty Gaines	svill	le/Ala	chua		City/County N	lumber				
Document	Source				Surveilla	veillance Method □ Active □ Passive □ Follow up □ Reabstraction □ Unknown							
	oort initiate a ne No □ Unknow		investigation?	•	Report M	ledium visit □ 2	2-Mailed	□ 3-Faxed □ 4	l-Phone	□ 5-El	ectronic	transfer □ 6-CD/disk	
III. Facili	ty Providing	Infor	nation (reco	ord a	II dates	as mm/d	d/yyyy)						
Facility Na	me									*Phone			
*Street Add	Iress									()			
City			County				State/	Country		*ZIP Cod	de		
Facility	Inpatient:			_		cian's office		ing, Diagnostic, Re	ferral Ag			acility: □ Emergency room	
Туре	☐ Hospital☐ Other, specify _		☐ Adult HI		C			☐ STD clinic r, specify				ratory Corrections Unknown, specify	wn
Date Form	Completed					ompleting				*Phone	- Other	, ѕреспу	_
IV. Patie	nt Demograp	ohics (record all da	ites	as mm/d	d/yyyy)				/			
	ned at Birth 🗆						of Birth	□ US □ Other/U	JS deper	ndency (s	pecify)		
Date of Bir	th/	/					Alias	Date of Birth	/	/			
				ate of Death / /					of Death				
Gender Ide	ntity	□ Man	□ Woman tional gender id		•	r man 🗆	Transgen	der woman					
5		□ Decli	ned to answer	ا 🗆	Jnknown								
Date Identi Sexual Orio		□ Strai	_/ <u></u> / ght or heterose:	vuol	Loshic	an or gov	□ Bisexu	ıal					
Sexual Offi	entation		tional sexual ori				□ Disext	ıaı					
			ned to answer			,, <u> </u>							_
Date Identi	fied												
Ethnicity		□ Hispa	anic/Latino □	Not H	ispanic/La	tino 🗆 Ur	nknown		Expan	ded Ethn	icity		
Race (check all th	nat apply)		rican Indian/Ala re Hawaiian/Oth				□ Black/A □ White	frican American □ Unknown	Expan	ded Race	•		
V. Reside	ence at Diag	nosis	(add additio	nal a	ddresse	s in Com	ments) (record all date	es as n	ım/dd/y	ууу)		
Address Ev (check all th		ess belov	w) □ Residend	ce at l	-llV diagno	osis □ Re	sidence at	stage 3 (AIDS) dia	agnosis	□ Check	k if <u>SAM</u>	E as current address	
Address Ty	/pe □ Residenti	al 🗆 B	ad address 🗆	Corre	ctional facil	ity Fost	ter home	□ Homeless □ N	Military	□ Other	□ Posta	al □ Shelter □ Temporary	
*Street Add	dress												
City			County				State/Co	untry				*ZIP Code	

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

HETEROSEXUAL contact with person who injected drugs	VI. Facility of Diagnosis	(add additional	facilities in Commen	ts)						
Street Address City	Diagnosis Type (check all that	apply to facility belo	w) □ HIV □ Stage 3	3 (AIDS) □ Ch	eck if <u>SAME</u> as	s facility pro	viding inform	nation		
County County County State County Facility Type Ingestient Flore Physical physical in County Count	Facility Name					*Pho	ne ()			
Facility Type	*Street Address									
Other, specify Othe	City	County		State/Count	try		*ZIP Code	9		
VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy) After 1977 and before the earliest known diagnosis of HIV infection, this patient had: Sex with made Sex with female Sex with		□ Adult HIV	clinic	□ CTS □ STI	D clinic	l Agency:	□ Laborator	y 🗆 Corre	ections	
VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy) After 1977 and before the earliest known diagnosis of HIV infection, this patient had: Sex with male Sex with female Sex with male Sex with female Sex with f	*Provider Name		*Provider Phone ()		Spec	ialtv			
After 1977 and before the earliset known diagnosis of HIV infection, this patient had: Sex with female			,	,						
Sex with female Q Yes No Unknown injected nonprescription drugs Q Yes Q No Unknown					ууу)	□ Pe	diatric R	isk (ent	er in	Comment
Received clotting factor for hemophilia/coagulation disorder Received clotting factor for hemophilia/coagulation disorder Bale received _ / _ / _ _ _ _ _ _ _ _	Sex with male						□Y	es 🗆 No	D	Unknown
Received clotting factor for hemophilial coagulation disorder Specify clotting factor. Date received _ / _ _ _ _ _ _ _ _ _	Sex with female						□Y	es 🗆 No	D	Unknown
Specify Colting factor. Date received	Injected nonprescription drugs						□Y	es 🗆 No	D	Unknown
HETEROSEXUAL contact with parson who injected drugs	Received clotting factor for hemo	ophilia/coagulation o	lisorder				□Y	es 🗆 No) [Unknown
HETEROSEXUAL contact with berson who injected drigs Tyes	Specify clotting factor:			Date recei	ved /					
HETEROSEXUAL contact with bisexual male HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	HETEROSEXUAL relations wit	th any of the follow	ving:							
HETEROSEXUAL contact with transfusion recipient with documented HIV infection Q	HETEROSEXUAL contact with p	erson who injected	drugs				□Y	es 🗆 No	D	Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection QYes No Unknown HETEROSEXUAL contact with transplant recipient with documented HIV infection QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection, risk not specified QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection, risk not specified QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection, risk not specified QYes No Unknown HETEROSEXUAL contact with person with documented HIV infection QYes No Unknown HETEROSEXUAL contact with transplant of tissue/organs or artificial insemination QYes No Unknown HETEROSEXUAL contact with present of the person with documented HIV infection QYes No Unknown HETEROSEXUAL contact with transfusion of bloody documented HIV infection QYes No Unknown HETEROSEXUAL contact with transfusion for the person of the person with documented HIV infection QYes No Unknown HETEROSEXUAL contact with transfusion of the person of the person with the person of the person	HETEROSEXUAL contact with b	isexual male					□Y	es 🗆 No	D	Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection, risk not specified	HETEROSEXUAL contact with p	erson with hemoph	ilia/coagulation disorder wi	th documented H	HIV infection		□Y	es 🗆 No	D	Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	HETEROSEXUAL contact with t	ransfusion recipient	with documented HIV infe	ction			□Y	es 🗆 No) [Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) Yes	·) _□	Unknown
First date received	·							es 🗆 No	O	Unknown
First date received								es 🗆 No) [Unknown
Received transplant of tissue/organs or artificial insemination Worked in a healthcare or clinical laboratory setting Grocupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: Other documented risk (include detail in Comments) VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy) Suspect acute HIV Infection? If YES, complete the two items below, enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, yield of signifysmptom onset of signifysmptom onset of signifysmptom onset of victions and provider regord of previous negative HIV test result data in Laboratory Data section, and enter patient or provider regord of previous negative HIV test result in HIV Testing History section. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, yield of provider signs/symptom onset of victions of signs/symptom onset of victions of signs/symptom onset of victions. Other evidence suggestive of acute HIV infection? If YES, describe: Diagnosis Dx Date Diagnosis Cardidiasis, esophageial Historyasicnicated or extrapulmonary Carcinoma, invasive cervical Scappilanicated or extrapulmonary Corpicocococis, disseminated or extrapulmonary Carcinoma, invasive cervical Dx Date Diagnosis Dx Date Dx Da					/					
Worked in a healthcare or clinical laboratory setting If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: Other documented risk (include detail in Comments) VIII. Clinical: Acute HIV Infection and Opportunistic Illinesses (record all dates as mm/dd/yyyy) Suspect acute HIV infection? If YES, complete the two items below: enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result HIV 17 Infection? If YES, complete the two items below: enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result flats in Laboratory Data section, and enter patient or provider report of previous negative HIV test result flats in Laboratory Data section, and enter patient or provider report of previous negative HIV test result flats in Laboratory Data section, and enter patient or provider report of previous negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result data in Laboratory Data section, and enter patient in HIV Testing History section. Other evidence suggestive of acute HIV infection? If YES, describe: Other evidences suggestive of acute HIV infection? If YES, describe: Data Data Diagnosis Dx Date Diagn								es 🗆 No	. .	Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: Other documented risk (include detail in Comments) VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy) Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute and syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute and syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom conset in the consistent vith acute and syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy. If YES, describe: YES			Similation .							
as primary mode of exposure, specify occupation and setting: Other documented risk (include detail in Comments) VIII. Clinical: Acute HIV Infection and Opportunistic Illinesses (record all dates as mm/dd/yyyy) VIII. Clinical: Acute HIV Infection and Opportunistic Illinesses (record all dates as mm/dd/yyyy) Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of signs/symptom onset. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of signs/symptom onset. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of signs/symptom onset. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of signs/symptom onset. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of signs/symptom onset. Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of lyes of signs/symptom onset. Clinical signs/symptoms consistent syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of lyes of lyes of signs/symptom onset. Clinical signs/symptoms consistent syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of lyes of lyes of lyes of signs/symptom onset. Clinical signs/symptoms consistent syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lyes of lyes		<u>-</u>						C3 140		OTIKITOWIT
VIII. Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)		, .								
Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section [cg. q. fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy?] Date of sign/symptom sonsistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy?] Date of sign/symptom sonset [] / Other evidence suggestive of acute HIV infection? If YES, describe:	Other documented risk (include	detail in Comments)					□Y	es 🗆 No	D	Unknown
Suspect acute HIV infection? If YES, complete the two items below; enter documented negative HIV test result data in Laboratory Data section, and enter patient or provider report of previous negative HIV test result in HIV Testing History section [cg. q. fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy?] Date of sign/symptom sonsistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy?] Date of sign/symptom sonset [] / Other evidence suggestive of acute HIV infection? If YES, describe:	VIII. Clinical: Acute HIV	Infection and	Onnortunistic Illne	eses (record	l all dates as	s mm/dd/v	vvv)			
Diagnosis Dx Date Dx	and enter patient or provider report of Clinical signs/symptoms consist lymphadenopathy)? Date of si Other evidence suggestive of ac	f previous negative HIV ent with acute retro- gn/symptom onset cute HIV infection?	/ test result in HIV Testing His viral syndrome (e.g., fever // If YES, describe:	tory section , malaise/fatigue	, myalgia, phar	yngitis, rash	١,	□ Yes	□ No	□ Unknov
Candidiasis, bronchi, trachea, or lungs	Opportunistic Illnesses									
bronchitis, pneumonitis, or esophagitis	Diagnosis Candidiania branchi traches ar lungo	Dx Date		ro (>1 mo duration)				1		Dx Date
Carcinoma, invasive cervical Isosporiasis, chronic intestinal (>1 mo. duration) Mycobacterium, of other/unidentified species, disseminated or extrapulmonary Cocidioidomycosis, disseminated or extrapulmonary Cryptospociosis, extrapulmonary Lymphoma, Burkitt's (or equivalent) Pneumonia, recurrent, in 12 mo. period Cryptosporidosis, chronic intestinal (>1 mo. Lymphoma, Burkitt's (or equivalent) Progressive multifocal leukoencephalopathy Cryptosporidosis, chronic intestinal (>1 mo. Lymphoma, immunoblastic (or equivalent) Progressive multifocal leukoencephalopathy Cytomegalovirus disease (other than in liver, spleen, or nodes) Lymphoma, primary in brain Salmonella septicemia, recurrent Salmonella septicemia, recu	Candidiasis, bronchi, trachea, or lungs					W. tuberculo	sis, puimonary			
Carcinoma, invasive cervical Isosporiasis, chronic intestinal (>1 mo. duration) Mycobacterium, of other/unidentified species, disseminated or extrapulmonary Pneumocystis pneumonia	Candidiasis, esophageal		Histoplasmosis, disseminated	or extrapulmonary				d or		
Cocidioidomycosis, disseminated or extrapulmonary Cryptococcosis, extrapulmonary Cryptococcosis, extrapulmonary Cryptococcosis, extrapulmonary Cryptosporidiosis, chronic intestinal (>1 mo. duration) Cryptomegalovirus disease (other than in liver, spleen, or nodes) Cryptomegalovirus retinitis (with loss of vision) Cryptomegalov							identified spe	ecies,		
Cryptococcosis, extrapulmonary	Coccidioidomycosis, disseminated or Kaposi's sarcoma Pneumocystis pneu						nary			
Cytomegalovirus disease (other than in liver, spleen, or nodes) Cytomegalovirus retinitis (with loss of vision) Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary HIV encephalopathy If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) HIV Immunoassays TEST HIV-1 A HIV-1/2 A HIV-1/2 Ag/Ab HIV-2 A Test Brand Name/Manufacturer Facility Name Result Positive Negative Indeterminate Lab Name Provider Name Collection Date /			Lymphoma, Burkitt's (or equiv	/alent)		Pneumonia,	recurrent, in 12	2 mo. period		
Cytomegalovirus retinitis (with loss of vision) Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary HIV encephalopathy Wasting syndrome due to HIV If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) HIV Immunoassays TEST HIV-1 A HIV-1/2 A HIV-1/2 Ag/Ab HIV-2 A Test Brand Name/Manufacturer Facility Name Result Positive Negative Indeterminate Collection Date / _ /	duration)		· · · · · · · · · · · · · · · · · · ·	r equivalent)					athy	
disseminated or extrapulmonary age HIV encephalopathy Wasting syndrome due to HIV If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) HIV Immunoassays		iver,	Lymphoma, primary in brain			Salmonella s	epticemia, rec	urrent		
IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) HIV Immunoassays TEST HIV-1 A HIV-1/2 A HIV-1/2 Ag/Ab HIV-2 A Test Brand Name/Manufacturer Facility Name Result Positive Negative Indeterminate Collection Date /_ /	Cytomegalovirus retinitis (with loss of vision) Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary Toxoplasmosis of brain, onset at >1 mo. of age									
IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy) HIV Immunoassays TEST	HIV encephalopathy	hubanania dia massis s	have married DVCT Casa Novemb			Wasting synd	drome due to H	IV		
HIV Immunoassays TEST HIV-1 A HIV-1/2 A HIV-1/2 Ag/Ab HIV-2 A Test Brand Name/Manufacturer Facility Name Result Positive Negative Indeterminate Lab Name Provider Name Collection Date /	•		•		: Camanan4	a) (na a and	all datas		all /	
TEST HIV-1 A HIV-1/2 A HIV-2 A HIV-2 A Test Brand Name/Manufacturer		ora additional te	ests and tests not spe	ecitiea pelow	ın Comment	s) (record	all dates	as mm/d	a/yy	уу)
Facility Name Provider Name Result Positive Negative Indeterminate Provider Name Collection Date//		A □ HIV-1/2 Ag/Ab	□ HIV-2 IA							
Result Desitive Desitive Indeterminate Collection Date//		er		Lab Name _						
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, result directly observed by a provider² □ Lab test, self-collected sample		□ Indotorminate		Provider Na	me	1				
			y provider □ Self-test, res	ult directly obse	rved by a provi	′ der² □ Lab t	test, self-col	lected sam	nple	

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

	med below in comments) (record all dates as min/dd/yyyy) (cont)
TEST ☐ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between H	
Test Brand Name/Manufacturer	Provider Name
Result Overall: □ Reactive □ Nonreactive	Collection Date//
Analyte results: HIV-1 Ag: □ Reactive □ Nonreactive HIV-1/2 Al	
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, re	
TEST ☐ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates a	mong HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test Brand Name/Manufacturer	Lab Name
Facility Name Result ³ Overall interpretation: Reactive Nonreactive Index Value	Provider Name
Result's Overall interpretation: Reactive Nonreactive Index Value	Collection Date / /
Analyte results: HIV-1 Ag: □ Reactive □ Nonreactive □ Not report	undifferentiated Index Value
HIV-2 Ab: □ Reactive □ Nonreactive □ Reactive □	
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, re	
TEST ☐ HIV-1/2 type-differentiating immunoassay (supplemental) (differentiation	
Test Brand Name/Manufacturer	Lab Name
Facility Name	Provider Name
Result ⁴ Overall interpretation: □ HIV positive, untypable □ HIV-1 positive	
☐ HIV negative ☐ HIV indeterminate ☐ HI Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate	V-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV-1 positive ☐ HIV-2 positive
HIV-2 Ab: Positive Negative Indeterminate HIV-2 Ab: Positive Negative Indeterminate	
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, re	
TEST HIV-1 WB HIV-1 IFA HIV-2 WB	,
Test Brand Name/Manufacturer	Lab Name
Facility Name	Provider Name
Result □ Positive □ Negative □ Indeterminate	Collection Date//
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, res	sult directly observed by a provider ² Lab test, self-collected sample
HIV Detection Tests	Lab Maura
TEST □ HIV-1/2 RNA NAAT (Qualitative) Test Brand Name/Manufacturer	Lab Name
Facility Name	Collection Date//
Result □ HIV-1 □ HIV-2 □ Both (HIV-1 and HIV-2) □ HIV, not differential	
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, re	
TEST □ HIV-1 RNA NAAT (Qualitative and Quantitative)	
Test Brand Name/Manufacturer	_Lab Name
Facility Name_	_ Provider Name
Result Qualitative: □ Reactive □ Nonreactive Analyte results: HIV-1 Quantitative: □ Detectable above limit □ Det	
Analyte results. The T Quantitative. 🗆 Detectable above in it	Copies/mLLog
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, res	sult directly observed by a provider ² □ Lab test, self-collected sample
TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA	
Test Brand Name/Manufacturer	Lab Name
Facility Name	Provider Name
Result □ Positive □ Negative □ Indeterminate	Collection Date//
Testing Option (if applicable) ☐ Point-of-care test by provider ☐ Self-test, resu	
TEST ☐ HIV-1 RNA/DNA NAAT (Quantitative) ☐ HIV-2 RNA/DNA NAAT (Qu	
Test Brand Name/Manufacturer	Lab Name Provider Name
Facility Name	ow limit □ Not detected Copies/mL Log
Collection Date	
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, resu	It directly observed by a provider² □ Lab test, self-collected sample
Drug Resistance Tests (Genotypic)	
TEST □ HIV-1 Genotype (Unspecified)	Test Brand Name/Manufacturer
Lab Name	Facility Name
Immunologic Tests (CD4 count and percentage)	Conection Date
CD4 count cells/µL CD4 percentage %	Collection Date / /
Test Brand Name/Manufacturer	Lab Name
Facility Name	Provider Name
Documentation of Tests	
Did documented laboratory test results meet approved HIV diagnostic algorithms	
If YES, provide specimen collection date of earliest positive test result for	this algorithm//
DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alor	
Is earliest evidence of HIV infection diagnosis documented by a physician If YES, provide date of diagnosis by physician	_
Date of last documented negative HIV test result (before HIV diagnosis date Specify type of test:	/ _
Testing Option (if applicable) □ Point-of-care test by provider □ Self-test, resu	

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

³Complete the overall interpretation and the analyte results.

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

X. Treatment/Services Referrals (record all dates as r	nm/dd/yyyy)						
· · · · · · · · · · · · · · · · · · ·	atient's partners will be notified about t alth dept □ 2-Physician/Provider □ 3	•					
Evidence of receipt of HIV medical care other than laboratory test □ 1-Yes, documented □ 2-Yes, client self-report, only Date of me	result (select one; record additional evided dical visit or prescription / /	•					
For Female Patient	alear view or procentialer	· 					
This patient is receiving or has been referred for gynecological or obstetrical services	Is this patient currently pregnant?	Has this patient delivered live-born infants?					
	·						
For Children of Patient (record most recent birth in these boxes; re							
*Child's Name Child's Last Name Soundex	Child's State Number	ild's Date of Birth///					
	Child's State Number	*Phone					
Facility Name of Birth (if child was born at home, enter "home birth")		Phone ()					
Facility Type Inpatient: Outpatient:	Other Facili	ity: □ Emergency room					
		ns Unknown					
☐ Other, specify	•	ecify					
*Street Address	· · ·	*ZIP Code					
City	tv	State/Country					
	•	, , , , , , , , , , , , , , , , , , , ,					
XI. Antiretroviral Use History (record all dates as mm/	dd/yyyy)						
Main source of antiretroviral (ARV) use information (select one)	- NUMBER - Other	Date patient reported information					
□ Patient interview □ Medical record review □ Provider rep	oort NHM&E Other	/					
Ever taken any ARVs?							
If yes, reason for ARV use (select all that apply)							
□ HIV Tx ARV medications							
□ PrEP ARV medications							
□ PEP ARV medications	Date began / / /	Date of last use / / /					
□ PMTCT ARV medications Date began// Date of last use//							
□ HBV Tx ARV medications	Date began / / /	Date of last use / / /					
□ Other (specify reason)							
ARV medications	Date began / / /						
XII. HIV Testing History (record all dates as mm/dd/yyy	ry)						
Main source of testing history information (select one)		Date patient reported information					
□ Patient interview □ Medical record review □ Provider report □	□ NHM&E □ Other						
Ever had previous positive HIV test result? Yes No Un		result / /					
Was the first positive test result from a self-test performed by the	·						
Ever had a negative HIV test result? Yes No Unknown	·	result (if date is from					
-	a lab test with test type, enter in	Lab Data section) / / /					
Was the last negative test result from a self-test performed by the							
Number of negative HIV test results within the 24 months before the first positive test result Unknown							
How many of these negative test results were from self-tests perfe	ormed by the patient? □ Unkn	own					
XIII. Comments							
CHECK OOS STATE:	If pregnant lis	t EDD (due date)://					
_ 	ii pregnant, ns	t EDD (duc date).					
DOC#							
TO A MAD TIADO ()							
Link with e-HARS stateno(s):							
XIV. *Local/Optional Fields		NIR Status:					
STARS#	N	IR OP Date://					
Other Risks: A B/C D F M V J O NIR CL Date://							
Hepatitis: A B C Other UNKnown		IIR RE Date:/					
Test & Treat (Yes/No)	Initials						
	mittals	Source code.					

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