



State of Louisiana
Department of Health and Hospitals
Office of Public Health
CONFIDENTIAL REPORTING WORKSHEET

Pt. Name: _____ MRN: _____ SS#: _____ - - -
 Address: _____ Tel: () _____ -
 City: _____ Parish: _____ State: _____ Zip: _____

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _ / _ / _	Country of Birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____	Date of death: _ / _ / _	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other
Hispanic Ethnicity: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Unknown			

Diagnostic Testing (Positive test results)	Collection Date (mm/dd/yyyy)	Ordering Site (if other than Reporting Facility)	Patient History / Risk Factors <i>(please complete all lines)</i>		
			Yes	No	Unk
<input type="checkbox"/> IA-1/2 <input type="checkbox"/> Ag/Ab Combo Was the above a rapid test? Y N	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sex with male
<input type="checkbox"/> Western Blot <input type="checkbox"/> IFA <input type="checkbox"/> Multispot 1__ 2__ 1&2__	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sex with female
Qualitative viral detection tests: <input type="checkbox"/> DNA or RNA PCR (Qual) <input type="checkbox"/> p-24 antigen <input type="checkbox"/> Other (specify): _____	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Injected nonprescription drugs
<i>If lab results not available, date dx documented at Reporting Facility:</i>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heterosexual relations with (check all that apply): <input type="checkbox"/> Injecting Drug User <input type="checkbox"/> Bisexual Male (for female pts) <input type="checkbox"/> Person with hemophilia/coagulation disorder <input type="checkbox"/> Transfusion/transplant recipient <input type="checkbox"/> Person with known HIV infection
Most recent negative test: <input type="checkbox"/> per lab report <input type="checkbox"/> per pt history	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rec'd clotting factor for hemophilia/coag. disorder <input type="checkbox"/> Rec'd transfusion of other blood/blood components Dates (mo/yr): Earliest _____ Latest _____
Clinical Status			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rec'd tissue/organ transplant or artificial insemination <input type="checkbox"/> Blood/body fluid exposure in a healthcare or clinical lab setting (mo/yr): ___/___ <i>(Include details on reverse)</i>
<input type="checkbox"/> Viral load (Quantitative NAAT RNA/DNA) Copies: _____	/ /				
<input type="checkbox"/> CD4 T-lymphocyte count/percent Count _____ %: _____	/ /				

Opportunistic Infections (OIs) - please note any past or current OI diagnoses <i>(see list on reverse)</i> : _____ _____	Date of Dx: _ / _ / _ _ / _ / _	Treatment History	
		Has pt ever taken antiretroviral medications (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pt currently on ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either, name of medications: _____		Date of earliest ARV use: _ / _ / _	Last date used: : _ / _ / _ <input type="checkbox"/> Ongoing

For Female Patients:
 Is the patient currently pregnant? Yes No Unk If yes, estimated date of delivery: _____ / _____ / _____
 Has the patient delivered a live-born infant since 1977? Yes No Unk If yes, date of last delivery: _____ / _____ / _____
 Delivery hospital (last live-born infant): _____ City/State: _____

Patient Notification: Has the patient been notified of his/her HIV test results? YES NO
Partner Services: (see reverse for info)
 I give Office of Public Health staff permission to conduct partner services for this patient.
 I will conduct partner notification for this patient.
 I have discussed partner notification with this patient and s/he will notify partners.

Reporting Facility: _____ Date: _____	Please send form to: James Hubbard or Connie Gordon DHH Office of Public Health / SHP 1450 Poydras St, Ste 2136 New Orleans, LA 70112 (504) 568-5453 / (504) 599-0496
Address: _____ City: _____ State: _____ Zip: _____	
Reporting Physician: _____ Phone: () _____	
Person Completing Form: _____ Phone: () _____	

To Our Providers:

This worksheet was developed to assist with timely reporting of HIV cases by the diagnosing and/or managing physician, by collecting the most critical information for completion of the Centers for Disease Control and Prevention's Adult Case Report Form, by staff of the Dept of Health and Hospitals Office of Public Health (DHH-OPH) STD/HIV Program (SHP). In some cases SHP staff may need to contact the provider for additional information not included on this worksheet. If providers prefer to complete the CDC Adult Case Report Form themselves, copies may be obtained from the SHP contact listed at the bottom of the form. Reports may also be made by phone to the designated contact, or completed on site chart via review. *Please include all available information; partial or approximate dates are acceptable for historical information.*

Reporting Requirements: Louisiana's Public Health Sanitary Code (Title 51, Part II, Chapter 1) requires that any physician practicing medicine in the State of Louisiana who attends, examines, or prescribes to a person with HIV infection must report the case by the end of the work week after the existence of a case, suspected case, or a positive laboratory result is known. HIV infection in pregnancy and perinatal HIV exposure are reportable within one business day. Other health care providers and entities, as well as laboratories, have similar reporting requirements.

HIPAA Guidelines Related to Disclosures for Public Health Activities: The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. See 45 CFR 164.512(b)(1)(i).

Partner Services: OPH staff will make a good faith effort to notify individuals who are spouses, sexual contacts, and/or needle-sharing partners of persons with HIV infection of their exposure, offer them counseling about their risk of infection, and offer testing for HIV infection. In performing this activity, OPH staff will initially contact the primary medical provider of the person who has HIV infection, if such provider can be identified, to determine how this notification will be conducted. If neither the infected person nor the medical provider intends to notify the spouse, sexual partner(s), and/or needle-sharing partner(s) of the exposure, OPH staff will attempt to interview the infected person directly to identify these partners for counseling, testing, and referral. Notification of partners is conducted in such a manner as to maintain the confidentiality of the infected person.

Partner Services is a valuable prevention activity. Newly diagnosed cases of HIV have top priority; however, persons who have previously been offered the service and need partner notification services again may also be referred to the DHH Office of Public Health for follow-up.

As a part of this process, OPH staff will offer follow-up services to newly diagnosed HIV infected patients, as needed. Follow-up services encourage HIV infected individuals to access early intervention therapies; provide important referrals to medical and social services; and prevent further transmission of HIV. Services include, but are not limited to, posttest counseling for individuals who did not return for test results, patient education/counseling, appropriate medical and social service referrals, linkages to community support groups, and case management services.

Opportunistic Infections (OIs):

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

Comments (e.g. additional risk info, antiretroviral meds, partner info):
