Annex 3.4.7 Model case report forms (adults, children)

WORLD HEALTH ORGANIZATION

ADULT (≥15 YEARS) HIV CASE REPORT FORM

REGISTRATION

Reporting date __ __ /__ __ /__ __ __ __
MM / DD / YEAR

Name and telephone number of person completing form _____

REPORTING FACILITY

Reporting facility Name_____
Address_____
_____
_____

Telephone number_____
_____

Facsimile number_____
_____

Facility/service type
☐ Hospital: inpatient
☐ Antenatal/obstetrics/gynaecology clinic/ prevention of mother-to-child transmission programme
☐ HIV care and treatment clinic
☐ Voluntary testing and counselling programme
☐ Drug treatment clinic
☐ Needle exchange programme
☐ Sexually transmitted disease clinic
☐ TB clinic
☐ Physician office/primary care clinic
☐ Voluntary testing and counselling programme/HIV counselling and testing outreach/home-based counselling and testing
☐ Maternal child health
☐ Emergency department
☐ Correctional facility
☐ Coroner/mortuary
☐ Family planning clinic
☐ Other: _____ (specify)
☐ Unknown

Did this patient receive his or her HIV diagnosis at a different facility? ☐ Yes ☐ No
[If Yes, complete information on diagnosing facility below]

Facility name where patient received diagnosis: _____

PATIENT PROFILE

Patient name:
First name_____ **Middle name**_____ **Surname**_____

Other name(s)/alias_____ **Sex**: ☐Male ☐ Female

Address: _____
_____

Date of birth: _ _ / _ _ / _ _ _ _
MM / DD / YEAR
Country of birth:
_____

Phone no._____

National identity number:
_____

ANC/PMTCT number:_____

Clinic number:
_____

Soundex of surname:
_____

Other unique identifier:
_____

HIV TESTING AND DIAGNOSIS

Test type	Test date	Test result	Test type	Test date	Test result
First HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative ☐ Indeterminate	p24 antigen	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
Second (confirmatory) HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative ☐ Indeterminate	RNA polymerase chain reaction (PCR)	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
Third HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative	Proviral DNA	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
HIV serological antibody test (ELISA/EIA)	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative	HIV culture	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
HIV Indirect	_ _ / _ _ / _ _ _ _	☐ Positive	HIV Recent	_ _ / _ _ / _ _ _ _	☐ Recent

Fluorescent antibody test	MM / DD / YEAR	☐ Negative	Infection Testing Algorithm	MM / DD / YEAR	☐ Longstanding
HIV western blot test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative			

Date of last negative (most recent) HIV test (if any)
_ _ / _ _ / _ _ _ _
MM / DD / YEAR

Place of last negative HIV test _____

HIV CARE AND TREATMENT

Date first enrolled in HIV care: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Transferred in: ☐ Yes ☐ No ☐ Unknown
Complete if transferred in from another facility

Transfer in date: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Name of previous facility: _____

Date started ART: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

On ART at previous clinic (facility from which patient transferred care): ☐ Yes ☐ No ☐ Unknown

Co-trimoxazole dispensed: ☐ Yes ☐ No

Date co-trimoxazole first dispensed: _ _ / _ _ / _ _ _ _
MM / DD / YEAR

Discordant couple: ☐ Yes ☐ No

ANTIRETROVIRAL (ARV) THERAPY

Date started on 1st line: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Regimen: _____

Date switched on 2nd line: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Regimen: _____

TUBERCULOSIS STATUS

Tuberculosis diagnosed: ☐ Yes

Date of TB diagnosis: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

TB treatment: ☐ Yes ☐ No

Date started on TB treatment: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

WHO STAGE

Diagnosed WHO stage III: ☐ Yes

Date first diagnosed WHO stage III: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Diagnosed WHO stage IV: ☐ Yes

Date first diagnosed WHO stage VI: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

MATERNAL HISTORY FOR FEMALE PATIENTS ONLY

Is this patient currently pregnant ☐ Yes ☐ No

Information on any of this patient's liveborn infants:

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

_____

_____

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ __ ☐ Unknown
MM / DD / YEAR

Place of Birth (name and address of hospital):

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ __ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

ADDITIONAL LABORATORY RESULTS	
Fisrt CD4 T cell count and percentage ☐ **CD4 count:** ____ cells/µL ☐ **CD4 percentage:** ____%	**Date of collection**: __ __ / __ __ / __ __ __ __ MM / DD / YEAR Date source: ☐ Laboratory record ☐ Medical record/HIV patient card
Most recent CD4 T cell count and percentage (if not first CD4 Test) ☐ **CD4 count:** ____ cells/µL ☐ **CD4 percentage:** ____%	**Date of collection**: __ __ / __ __ / __ __ __ __ MM / DD / YEAR Date source: ☐ Laboratory record ☐ Medical record/HIV patient card
First viral load test ☐ Detectable **copies/µL**: _____ **log**:_____ ☐ Undetectable	**Date of collection**: __ __ / __ __ / __ __ __ __ MM / DD / YEAR
Most recent viral load test (if not first CD4 test) ☐ Detectable **copies/µL**: _____ **log**:_____ ☐ Undetectable	**Date of collection**: __ __ / __ __ / __ __ __ __ MM / DD / YEAR
PROBABLE ROUTE OF TRANSMISSION (CHECK ALL THAT APPLY)	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected drugs	☐ Yes ☐ No ☐ Unknown
Received blood or blood product transfusion or transplant	☐ Yes ☐ No ☐ Unknown
IF PROBABLE ROUTE OF TRANMISSION IS HETEROSEXUAL CONTACT:	
Heterosexual contact with HIV-infected person (unknown risk)	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with person who injects drugs	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with bisexual male	☐ Yes ☐ No ☐ Unknown
Heterosexual contact with sex worker or client of sex worker	☐ Yes ☐ No ☐ Unknown
TRANSFER OUT AND DEATH	
Date of transfer: __ __ / __ __ / __ __ __ __	**Name and location of facility patient transferred to:** _____
Date of loss to follow up: __ __ / __ __ / __ __ __ __	
Date of death: __ __ / __ __ / __ __ __ __ MM / DD / YEAR	**Cause of death:** ☐ HIV related ☐ Non-HIV related
Place of death: _____	
MINISTRY OF HEALTH USE ONLY	
Date received : __ __ / __ __ / __ __ __ __ MM / DD / YEAR	
Type of report: ☐ New case ☐ Follow-up information/sentinel events for a previously reported case	

Comments: Countries should adapt the form to meet their specific situation, including additional information on other demographic characteristics such as race or ethnicity, transmission risk categories, types of facilities, etc.

WORLD HEALTH ORGANIZATION

PAEDIATRIC (<15 YEARS) HIV CASE REPORT FORM

REGISTRATION

Reporting Date __ __ /__ __ /__ __ __ __
MM / DD / YEAR

Name and telephone number of person completing form
_____

REPORTING FACILITY

Reporting facility :
Name_____
Address_____
_____
_____

Telephone number_____
_
Facsimile number_____
__

Facility/service type
☐ Hospital: inpatient
☐ Antenatal/obstetrics/gynaecology clinic/ prevention of mother-to-child transmission programme
☐ HIV care and treatment clinic
☐ Voluntary testing and counselling programme
☐ Drug treatment clinic
☐ Needle exchange programme
☐ Sexually transmitted disease clinic
☐ TB clinic
☐ Physician office/primary care clinic
☐ Voluntary testing and counselling programme/HIV counselling and testing outreach/home-based counselling and testing
☐ Maternal child health
☐ Emergency department
☐ Correctional facility
☐ Coroner/mortuary
☐ Family planning clinic
☐ Other: _____ (specify)
☐ Unknown

Did this patient receive his or her HIV diagnosis at a different facility? ☐ Yes ☐ No
[If Yes, complete information on diagnosing facility below]

Facility name where patient received diagnosis: _____

PATIENT PROFILE

Patient name:
First name_____ **Middle name**_____ **Surname**_____

Other name(s)/alias_____ **Sex**: ☐Male ☐ Female

Address: _____
_____

Date of birth: _ _ / _ _ / _ _ _ _
MM / DD / YEAR
Country of birth:
_____

Phone no._____

National identity number:
_____

ANC/PMTCT Number:_____

Clinic number:
_____

Soundex of surname:
_____

Other unique identifier:
_____

HIV TESTING AND DIAGNOSIS

Test Type	Test Date	Test Result	Test Type	Test Date	Test Result
First HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative ☐ Indeterminate	p24 antigen	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
Second (confirmatory) HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative ☐ Indeterminate	RNA polymerase chain reaction (PCR)	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
Third HIV rapid antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative	Proviral DNA	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative
HIV serological antibody test (ELISA/EIA)	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative	HIV culture	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative

HIV indirect fluorescent antibody test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative	HIV recent infection testing algorithm	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Recent ☐ Longstanding
HIV western blot test	_ _ / _ _ / _ _ _ _ MM / DD / YEAR	☐ Positive ☐ Negative			

Date of last negative (most recent) HIV test (if any)
_ _ / _ _ / _ _ _ _
MM / DD / YEAR

Place of last negative HIV test _____

HIV CARE AND TREATMENT

Date first enrolled in HIV care: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Transferred in: ☐ Yes ☐ No ☐ Unknown
Complete if transferred in from another facility

Transfer in Date: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Name of previous facility: _____

Date started ART: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

On ART at previous clinic (facility from which patient transferred care): ☐ Yes ☐ No ☐ Unknown

Co-trimoxazole dispensed: ☐ Yes ☐ No

Date co-trimoxazole first dispensed: _ _ / _ _ / _ _ _ _
MM / DD / YEAR

Discordant Couple: ☐ Yes ☐ No

ANTIRETROVIRAL (ARV) THERAPY

Date started on 1st line: __ __ / __ __ / __ __ __ __
MM / DD / YEAR **Regimen:** _____

Date switched on 2nd line: __ __ / __ __ / __ __ __ __
MM / DD / YEAR **Regimen:** _____

TUBERCULOSIS STATUS

Tuberculosis diagnosed: ☐ Yes

Date of TB diagnosis: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

TB treatment: ☐ Yes ☐ No

Date started on TB treatment: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

WHO STAGE

Diagnosed WHO stage III: ☐ Yes

Date first diagnosed WHO stage III: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

Diagnosed WHO stage IV: ☐ Yes

Date first diagnosed WHO stage VI: __ __ / __ __ / __ __ __ __
MM / DD / YEAR

MATERNAL HISTORY FOR FEMALE PATIENTS ONLY

Is this patient currently pregnant ☐ Yes ☐ No

Information on any of this patient's liveborn infants:

Child's name: _____ ☐ Unknown **child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

_____

_____

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

_____

_____

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown
MM / DD / YEAR

Place of birth (name and address of hospital):

_____

_____

Child's name: _____ ☐ Unknown **Child's date of birth:** __ __ / __ __ / __ __ __ _ ☐ Unknown

Place of birth (name and address of hospital):	MM / DD / YEAR
ADDITIONAL LABORATORY RESULTS	
First CD4 T cell count and percentage ☐ **CD4 count:** ____ cells/µL ☐ **CD4 percentage:** ____%	**Date of collection:** __ __ / __ __ / __ __ __ __ MM / DD / YEAR Date source: ☐ Laboratory record ☐ Medical record/HIV patient card
Most recent CD4 T cell count and percentage (if not first CD4 test) ☐ **CD4 count:** ____ cells/µL ☐ **CD4 percentage:** ____%	**Date of collection:** __ __ / __ __ / __ __ __ __ MM / DD / YEAR Date source: ☐ Laboratory record ☐ Medical record/HIV patient card
First viral load test ☐ Detectable **copies/µL**: _____ **log**:_____ ☐ Undetectable	**Date of collection:** __ __ / __ __ / __ __ __ __ MM / DD / YEAR
Most recent viral load test (if not first CD4 test) ☐ Detectable **copies/µL**: _____ **log**:_____ ☐ Undetectable	**Date of collection:** __ __ / __ __ / __ __ __ __ MM / DD / YEAR
HIV EXPOSURES (CHECK ALL THAT APPLY)	
Perinatal exposure ☐ Yes ☐ No ☐ Unknown	**Injected non-prescription drugs** ☐ Yes ☐ No ☐ Unknown
Sex with male ☐ Yes ☐ No ☐ Unknown	**Sex worker:** ☐ Yes ☐ No ☐ Unknown
Sex with female ☐ Yes ☐ No ☐ Unknown	**Received blood or blood product transfusion or transplant** ☐ Yes ☐ No ☐ Unknown
TRANSFER OUT AND DEATH	
Date of transfer: __ __ / __ __ / __ __ __ __	**Name and Location of facility patient transferred to:** _____
Date of loss to follow up: __ __ / __ __ / __ __ __ __	
Date of death: __ __ / __ __ / __ __ __ __ MM / DD / YEAR	**Cause of death:** ☐ HIV related ☐ Non-HIV related
Place of death: _____	
MINISTRY OF HEALTH USE ONLY	
Date received : __ __ / __ __ / __ __ __ __ MM / DD / YEAR	
Type of report: ☐ New case ☐ Follow-up information /sentinel events for a previously reported case	

Comments: Countries should adapt the form to meet their specific situation, including additional information on other demographic characteristics such as race or ethnicity, transmission risk categories, types of facilities, etc.