

**MICHIGAN ADULT HIV CONFIDENTIAL CASE REPORT**

(Patients ≥ 13 years of age)

Michigan Department of Health and Human Services

Fax Number: 313-456-1580

STATE #:

eHARS Entry Date:

Aphirm Entry Date:

**I. SURVEILLANCE USE ONLY**

Document ID <b>MI00-</b>	Soundex Code	Date Received at Surveillance
Aphirm Person ID Number	Sticky Number	Document Source
Report Status <input type="checkbox"/> New <input type="checkbox"/> Update	Report Medium <input type="checkbox"/> FV <input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> E	Surveillance Method <input type="checkbox"/> A <input type="checkbox"/> F <input type="checkbox"/> P <input type="checkbox"/> R

**II. PATIENT IDENTIFIER INFORMATION**

Patient Legal Name (Last, First, Middle)	<input type="checkbox"/> Alias <input type="checkbox"/> Maiden Name (Last, First, Middle)		
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Correctional <input type="checkbox"/> PO <input type="checkbox"/> Temporary <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Foster Home			
Current Address			
City	County	State	Zip Code
Phone Number	Mobile Number	Social Security Number	
Residence at Diagnosis (check all that apply) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at Stage 3 (AIDS) Diagnosis			
Address <input type="checkbox"/> Same as Current Address			
City	County	State/Country	Zip Code

**III. DEMOGRAPHIC INFORMATION – COMPLETE ALL FIELDS**

Case Status <input type="checkbox"/> HIV Infection <input type="checkbox"/> Stage 3 (AIDS)	Do you suspect this is an acute (recent) infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male to Female <input type="checkbox"/> Trans Female to Male		
Date of Birth	Alias Date of Birth	Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify)	
Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	Death Date	State/Territory of Death	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Lives with Partner			
Race <input type="checkbox"/> Black (African American) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian/PI			
Ethnicity Latino/Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk      Arab <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			





Patient Name: \_\_\_\_\_ State Number: \_\_\_\_\_  
                                     last                                    first

**HIV Genotype**

Laboratory	Collection Date
If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
If Yes, provide date of documentation by care provider	

**XI. STAGE 3 (AIDS) OPPORTUNISTIC ILLNESSES** (See instructions for a list of opportunistic illnesses)

Name of Opportunistic Illness	Illness Diagnosis Date
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**XII. HIV TESTING AND TREATMENT HISTORY (TTH)**

Date questions answered by patient	Main Source of the TTH Info <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Patient Interview <input type="checkbox"/> Provider Report <input type="checkbox"/> Other		
<b>First Positive Test Reported by Patient</b>			
Ever have previous positive HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date of 1 <sup>st</sup> positive HIV Test	Anonymous 1 <sup>st</sup> positive test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
<b>Negative Tests Reported by Patient</b>			
Ever test negative? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date of most recent negative test	Number of negative tests in 24 months before 1 <sup>st</sup> positive test <input type="checkbox"/> Unk	
<b>History of any Antiretroviral Treatment (ARV) Use</b>		<input type="checkbox"/> <b>Check Here if No ARV Use Ever</b>	
	ARV Used	Date Began	Date of Last Use
For HIV TX?			
For PrEP?			
For PEP?			
For Pregnant mom?			
Currently using ARV <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of most recent use	Date of last use	

**XIII. COMMENTS**

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.