

Please see the following pages for the AIDS Case Report Form.



HIV/AIDS Case Report Adult, Adolescent and Pediatric (non maternal-fetal) Cases

HIV
 AIDS
 New case report
 Update

For provincial/territorial use	For use by PHAC
Provincial/territorial ID Number	EPIC No.
Province/Territory to which case is attributed	Date received YY MM DD

SECTION I – PATIENT INFORMATION

Reporting physician's name	City	Telephone number ()
----------------------------	------	-------------------------

Hospital or clinic	City	Province/Territory
--------------------	------	--------------------

Is another physician providing ongoing care to this patient? Yes No

If so, please provide name, city and telephone number.

Name	City	Telephone number ()
------	------	-------------------------

Patient's initials First Middle Last <input type="text"/> <input type="text"/> <input type="text"/>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YY MM DD <input type="text"/> <input type="text"/> <input type="text"/>	Vital Status <input type="checkbox"/> Alive (If yes, date last known to be alive) <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Dead (If yes, date of death) <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> unknown
--	---	--	--	----------------------------------

• Is the patient: (please ask patient to assist you in answering this question)

<input type="checkbox"/> White	<input type="checkbox"/> South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, etc.)
<input type="checkbox"/> Black (e.g. African, Haitian, Jamaican, Somali, etc.)	<input type="checkbox"/> Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan, etc.)
<input type="checkbox"/> North American Indian	<input type="checkbox"/> Métis
<input type="checkbox"/> Asian (e.g. Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Laotian, Korean, Filipino, etc.)	<input type="checkbox"/> Inuit
<input type="checkbox"/> Latin-American (e.g. Mexican, Central/South American, etc.)	
<input type="checkbox"/> Other – includes mixed ethnicity (specify) → <input type="text"/>	

What language does this person speak most often at home?	Country of birth <input type="checkbox"/> Canada <input type="checkbox"/> Other (specify) → <input type="text"/>	Year of arrival in Canada
--	---	---------------------------

City and province/territory of residence at diagnosis City Province/Territory First 3 digits of Postal Code	Current city and province/territory of residence City Province/Territory First 3 digits of Postal Code
---	--

SECTION II – RISK(S) ASSOCIATED WITH THE TRANSMISSION OF HIV IN THIS PATIENT

• Since January 1978 and preceding the diagnosis of HIV/AIDS, this patient had: (check ALL that apply)

Yes	No	Unknown	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with a male.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex with a female.
Heterosexual sex with: (check ALL that apply)			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• an injection drug user;
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• a bisexual male;
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• a transfusion recipient with documented HIV infection;
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• a person with hemophilia/coagulation disorder;
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• a person born in a country where heterosexual transmission predominates. If yes, specify country → <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• a person with confirmed or suspected HIV infection or AIDS (whether or not risk factor is known).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injected non-prescription drugs (including steroids).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received pooled concentrates of factor VIII or IX for treatment of hemophilia/coagulation disorder. If yes, please complete Section 1 of the Supplement to HIV/AIDS Case Report.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transfusion of whole blood or blood components such as packed red cells, plasma, platelets or cryoprecipitate. If yes, please complete Section 2 of the Supplement to HIV/AIDS Case Report.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to HIV-contaminated blood or body fluids or concentrated virus in an occupational setting. If yes, specify occupation → <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other medical exposure (e.g., organ or tissue transplant, artificial insemination). If yes, please give details in Section VI "Additional Information or Comments".
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-medical, non-occupational exposure which could have been the source of the infection (e.g. acupuncture, tattoo, body piercing, breast milk). If yes, please give details of type of exposure, date and location in Section VI "Additional Information or Comments".

Since January 1978, has this patient donated blood, plasma, platelets, organs, tissues, semen or breast milk?
If yes, please give details of type of donation, date and location in Section VI "Additional Information or Comments". Yes No Unknown

Has the Red Cross or other appropriate donor program been notified? Yes No Unknown

Do you want a public health official to ensure this notification? Yes No Unknown

SECTION III – LABORATORY DATA

• Does this case have evidence, as defined in the above instructions, of HIV infection?
 Yes No Unknown

Date of first positive HIV test (if known)
 Year: Month:

Current CD4 count (if known)
 cells/μ l

SECTION IV – DISEASES INDICATIVE OF AIDS

DISEASES	Date of Diagnosis		Diagnostic method		DISEASES	Date of Diagnosis		Diagnostic method	
	Year	Month	Definitive	Presumptive		Year	Month	Definitive	Presumptive
Bacterial pneumonia, recurrent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> (disseminated or extrapulmonary)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis (bronchi, trachea or lungs)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mycobacterium of other species or unidentified species	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis (esophageal)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis</i> (disseminated or extrapulmonary) (Please complete SECTION V)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify Site:				
Coccidioidomycosis (disseminated or extrapulmonary)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Miliary <input type="checkbox"/> Pleurisy <input type="checkbox"/> Other respiratory				
Cryptococcosis (extrapulmonary)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C.N.S. <input type="checkbox"/> Bone and joint <input type="checkbox"/> Genitourinary				
Cryptosporidiosis (chronic intestinal, >1 mo. duration)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) → <input type="text"/>				
Cytomegalovirus disease (other than in liver, spleen or nodes)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. tuberculosis</i> (pulmonary) (Please complete SECTION V)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Pneumocystis carinii</i> pneumonia	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalopathy, HIV-related (dementia)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Progressive multifocal leukoencephalopathy	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration) or bronchitis, pneumonitis or esophagitis	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salmonella septicemia, recurrent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis (disseminated or extrapulmonary)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toxoplasmosis of brain	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal (>1 mo. duration)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wasting syndrome due to HIV	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diseases affecting pediatric cases only (<15 years old)				
Lymphoma, Burkitt's (or equivalent term)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bacterial infections, multiple or recurrent (excluding recurrent bacterial pneumonia)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent term)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoid interstitial pneumonia and/or Pulmonary lymphoid hyperplasia	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, primary in brain	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>					

SECTION V – TUBERCULOSIS

1. Before the diagnosis of AIDS, was this patient ever treated for tuberculosis? Yes – when? → Year: Month: No Unknown
2. Has this patient ever had a PPD skin test? Yes – What was the size in mm? → mm No Unknown
3. If the PPD test was negative, was the patient anergy tested? Yes No Unknown If yes, were any sites positive? Yes No Unknown

SECTION VI – ADDITIONAL INFORMATION OR COMMENTS

(Please use this section for information of interest about the acquisition of the virus, etc.)

Person completing this form <input type="text"/>	Telephone number (<input type="text"/>) <input type="text"/>	Date report completed YY MM DD <input type="text"/> <input type="text"/> <input type="text"/>
---	---	---

FOR PROVINCIAL/TERRITORIAL USE: To which exposure category has this patient been assigned?

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Men who have sex with men (MSM) | <input type="checkbox"/> Injection drug user (IDU) | <input type="checkbox"/> MSM and IDU | <input type="checkbox"/> Heterosexual – Endemic | <input type="checkbox"/> NIR – Heterosexual |
| <input type="checkbox"/> Blood transfusion recipient | <input type="checkbox"/> Clotting factor recipient | <input type="checkbox"/> Occupational exposure | <input type="checkbox"/> Heterosexual – Partner at risk | <input type="checkbox"/> NIR – Other |