

## HIV Notification Form

Please complete all sections



Panorama QA complete:  Yes  No  
Initials:

### A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	<b>FOR PUBLIC HEALTH OFFICE USE ONLY:</b> <b>Service Area:</b> <b>Date Received:</b> <b>Panorama Client ID:</b> <b>Panorama Investigation ID:</b>
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### B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD      Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Phone : <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace: <input type="checkbox"/> Alt Contact: Name: _____  Relationship: _____
Health Card Province: _____ Health Card Number (PHN): _____	<u>Gender Identity:</u> <input type="checkbox"/> Transgender Male-to-female <input type="checkbox"/> Transgender Female-to-male <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Other (specify)	Preferred Communication Method: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> E-mail <input type="checkbox"/> Text
Place of Employment/School:	Email Address:	
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description		
Mailing (Postal address):		
Street Address or FN Community (Primary Home):		

### C) IMMIGRATION INFORMATION

Country Born In: _____
Country Emigrated from: _____      Arrival Date: YYYY / MM / DD      OR Arrival Year YYYY

### D) DISEASE EVENT HISTORY

<b>Site / Presentation:</b> <input type="checkbox"/> Adults, adolescents, and children $\geq$ 18 months <input type="checkbox"/> Children <18 months
<b>Staging (see CDC Manual):</b> <input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1 (CD4 $\geq$ 500) <input type="checkbox"/> Stage 2 (CD4 200-499) <input type="checkbox"/> Stage 3 (CD4 <200) <input type="checkbox"/> Unknown

### E) SIGNS & SYMPTOMS

	YES	NO		YES	NO	SPECIFY
Asymptomatic			Symptoms prior to or at time of testing?			
Initial CD4 result						

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**F) RISK FACTORS (Please complete *all* Risk Factors from 3 months prior to last known negative result –specify dates as needed)**

Legend: N-No, NA-Not Asked, U-Unknown

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Sexual Behaviour – MSM +	TE		
Sexual Behaviour - Heterosexual Sex	TE		
Sexual Behaviour - Heterosexual sex with person who injects drugs	TE		
Sexual Behaviour - Heterosexual sex with MSM	TE		
Sexual Behaviour - Heterosexual sex with person with hemophilia/coagulation disorder	TE		
Sexual Behaviour - Heterosexual sex with person from endemic country (Add'l Info)			
Sexual Behaviour – Heterosexual sex with person with confirmed/suspected HIV/AIDS (Add'l Info)	YYYY / MM/DD		
Sexual Behaviour – Sex with a known case	YYYY / MM/DD		
Sexual Behaviour - Unknown/Anonymous Partner (Add'l Info)	TE		
Sexual Behaviour - E-partnering internet/apps (Add'l Info.)	TE		
Sexual Behaviour - Goods <b>provided</b> (food, shelter, money or drugs) in exchange for sex	TE		
Sexual Behaviour - Goods <b>received</b> (food, shelter, money or drugs) in exchange for sex	TE		
Sexual Behaviour - Events with multiple sexual partners (Add'l Info)	TE		
Exposure - Blood and body fluids (not otherwise listed) (Add'l Info.)	YYYY / MM/DD		
Exposure - Invasive body art (e.g. tattoo, body piercing, scarification)	YYYY / MM/DD		
Exposure - Non medical, non-occupational source (acupuncture, breastmilk) (Add'l Info)	YYYY / MM/DD		
Exposure - Occupational - HIV contaminated blood, body fluid	YYYY / MM/DD		
Special Population - Infant born to an infected mother	YYYY / MM/DD		
Special Population - From or residence in an endemic country (Add'l Info)			
Special Population – Pregnancy			
Special Population - Self-reported Indigenous			
Substance Use - Injection drug use (including steroids)	YYYY / MM/DD		
Risk Behavior - Sharing injection drug equipment	YYYY / MM/DD TE		
Medical Treatment - Blood, blood product or tissue recipient (Add'l Info.)	YYYY / MM/DD INTERVENTION		
Medical Treatment - Other (transplant, surgery, dental, oscopy, etc.) (Add'l Info)	YYYY / MM/DD INTERVENTION		
Blood, blood product, tissue or transplant donor	Document referral in Interventions and complete Appendix K – Referral to CBS, and upload into Document Management		
Unable to obtain Risk Factors <input type="checkbox"/> yes (not entered in Panorama – update in disposition)			

**G) UNKNOWN/ANONYMOUS CONTACTS**

Anonymous contacts: \_\_\_\_\_ (number of contacts that the individual cannot name)

Include known contacts on the following pages