Protected when completed

HIV/AIDS CASE REPORT ADULT, ADOLESCENT AND PEDIATRIC (NON MATERNAL-FETAL) CASES

☐ HIV ☐ AIDS ◯ New case report ◯ Update

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 ☐

Sex ◯ M ◯ F

Date of birth (YYYY-MM-DD)

Vital Status ◯ Alive (If yes, date last known to be alive) ◯ Dead (If yes, date of death)
Date (YYYY-MM-DD) ☐ ◯ Unknow

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

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

What language does this person speak most often at home?

Country of birth ◯ Canada ◯ Other (specify)

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	
◯	◯	◯	Sex with a male.
◯	◯	◯	Sex with a female.
			Heterosexual sex with: (check ALL that apply)
◯	◯	◯	• an injection drug user;
◯	◯	◯	• a bisexual male;
◯	◯	◯	• a transfusion recipient with documented HIV infection;
◯	◯	◯	• a person with hemophilia/coagulation disorder;
◯	◯	◯	• a person born in a country where heterosexual transmission predominates. If yes, specify country ☐
◯	◯	◯	• a person with confirmed or suspected HIV infection or AIDS (whether or not risk factor is known).
◯	◯	◯	Injected non-prescription drugs (including steroids).
◯	◯	◯	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.
◯	◯	◯	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.
◯	◯	◯	Exposure to HIV-contaminated blood or body fluids or concentrated virus in an occupational setting. If yes, specify occupation ☐
◯	◯	◯	Other medical exposure (e.g., organ or tissue transplant, artificial insemination). If yes, please give details in Section VI “Additional Information or Comments”.
◯	◯	◯	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”.
◯	◯	◯	Has the Red Cross or other appropriate donor program been notified?
◯	◯	◯	Do you want a public health official to ensure this notification?

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) (YYYY-MM) ☐

Current CD4 count (if known) (cells/μ l) ☐

SECTION IV – DISEASES INDICATIVE OF AIDS

Diseases	Date of Diagnosis (YYYY-MM)	Diagnostic method	
		Definitive	Presumptive
Bacterial pneumonia, recurrent		◯	◯
Candidiasis (bronchi, trachea or lungs)		☐	N/A
Candidiasis (esophageal)		◯	◯
Cervical cancer, invasive		☐	N/A
Coccidioidomycosis (disseminated or extrapulmonary)		☐	N/A
Cryptococcosis (extrapulmonary)		☐	N/A
Cryptosporidiosis (chronic intestinal, >1 mo. duration)		☐	N/A
Cytomegalovirus disease (other than in liver, spleen or nodes)		☐	N/A
Cytomegalovirus retinitis (with loss of vision)		◯	◯
Encephalopathy, HIV-related (dementia)		☐	N/A
Herpes simplex: chronic ulcer(s) (>1 mo. duration) or bronchitis, pneumonitis or esophagitis		☐	N/A
Histoplasmosis (disseminated or extrapulmonary)		☐	N/A
Isosporiasis, chronic intestinal (>1 mo. duration)		☐	N/A
Kaposi's sarcoma		◯	◯
Lymphoma, Burkitt's (or equivalent term)		☐	N/A
Lymphoma, immunoblastic (or equivalent term)		☐	N/A
Lymphoma, primary in brain		☐	N/A
Mycobacterium avium complex or M. kansasii (disseminated or extrapulmonary)		◯	◯
Mycobacterium of other species or unidentified species		◯	◯

Diseases	Date of Diagnosis (YYYY-MM)	Diagnostic method	
		Definitive	Presumptive
M. tuberculosis (disseminated or extrapulmonary) (Please complete SECTION V)		☐	N/A
Specify Site: ◯ Miliary ◯ Pleurisy ◯ C.N.S. ◯ Other respiratory ◯ Bone and joint ◯ Genitourinary Other (specify)			
M. tuberculosis (pulmonary) (Please complete SECTION V)		◯	◯
Pneumocystis carinii pneumonia		◯	◯
Progressive multifocal leukoencephalopathy		☐	N/A
Salmonella septicemia, recurrent		☐	N/A
Toxoplasmosis of brain		◯	◯
Wasting syndrome due to HIV		☐	N/A
Diseases affecting pediatric cases only (<15 years old)			
Bacterial infections, multiple or recurrent (excluding recurrent bacterial pneumonia)		☐	N/A
Lymphoid interstitial pneumonia and/or Pulmonary lymphoid hyperplasia		◯	◯

SECTION V – TUBERCULOSIS

Yes	No	Unknown	
◯	◯	◯	Before the diagnosis of AIDS, was this patient ever treated for tuberculosis? If yes, when? (YYYY-MM) ☐
◯	◯	◯	Has this patient ever had a PPD skin test? If yes, what was the size in mm? ☐
◯	◯	◯	If the PPD test was negative, was the patient anergy tested? 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

Telephone number

Date report completed (YYYY-MM-DD)

FOR PROVINCIAL/TERRITORIAL USE

Provincial/territorial ID Number

Province/Territory to which case is attributed

To which exposure category has this patient been assigned?

- Men who have sex with men (MSM)
- Injection drug user (IDU)
- MSM and IDU
- Heterosexual – Endemic
- NIR – Heterosexual
- Blood transfusion recipient
- Clotting factor recipient
- Occupational exposure
- Heterosexual – Partner at risk
- NIR – Other

FOR USE BY PHAC

EPIC No.

Date received (YYYY-MM-DD)

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