Instructions for Confidential Reporting of Human Immunodeficiency Virus (HIV) Cases to the New Mexico Department of Health (NMDOH)

Purpose of case report form

- The confidential HIV Case Report form is designed to collect information that promotes understanding of HIV infection morbidity and mortality in New Mexico.

Patients for whom reporting is indicated

- Each person with newly diagnosed HIV, stage 1, 2, or 3 (AIDS), or unknown stage.
- Each person with HIV infection progressing from an earlier or unknown stage to stage 3 (AIDS).
- Each person with HIV infection who is diagnosed with an Opportunistic Infection.
- In the event a person with HIV infection dies, this form should be used to report the new information.
- Each person with HIV infection who has been previously reported but for whom updated information is available such as additional risk factor information, or updated current address information.
- Each person with HIV infection who is relocating from another state and enrolling in care, even if they have been previously reported in New Mexico or another state.
- Case report forms should be submitted within one week (5 business days).

Who should report cases

- Any medical provider, laboratory, or organization that offers HIV testing by name (confidential testing) or provides care to persons with HIV infection must report.

How to report

- Complete the confidential HIV Case Report Form and submit to the Surveillance Coordinator by fax at (505) 476-3544 (secure fax line)

OR mail to:

New Mexico Department of Health
Surveillance Coordinator
Infectious Disease Epidemiology Bureau
1190 St. Francis Drive, Suite N1359
Santa Fe, NM 87505

Disposition of form

- The completed form is for NMDOH use only. De-identified information collected on this form is provided to the Centers for Disease Control and Prevention (CDC) in order to characterize HIV infection morbidity and mortality in the United States.

Legal basis for HIV reporting

- NMDOH conducts HIV surveillance as a public health authority defined by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Information; Final Rule (Privacy Rule) [45 CRF §164.501].
- 45 CFR §164.512(b) of the Privacy Rule expressly permits disclosures without individual authorization to public health entities that are authorized by law to collect or receive the information for the purpose of preventing or controlling disease. This includes the HIV surveillance activities that are conducted by the HIV/Hepatitis Epidemiology Program (Program) at NMDOH.
- Pursuant to New Mexico Statutes Annotated 1978 Section 9-7-6(E) and in conformity with Chapter 24, Article 1 ("the Public Health Act"), particularly sections 24-1-3C, 24-1-7, and 24-1-15, the New Mexico Department of Health is authorized, under the New Mexico Administrative Code Title 7 Chapter 4 Part 3, to receive reports of notifiable diseases or conditions. HIV infection is a Notifiable Condition in New Mexico pursuant to NMAC 7.4.3.13.

How to fill out a Confidential HIV Case Report Form

Section 1: Contact Information

Person Completing Form:_____ Facility:_____ Phone:_____Date:_____

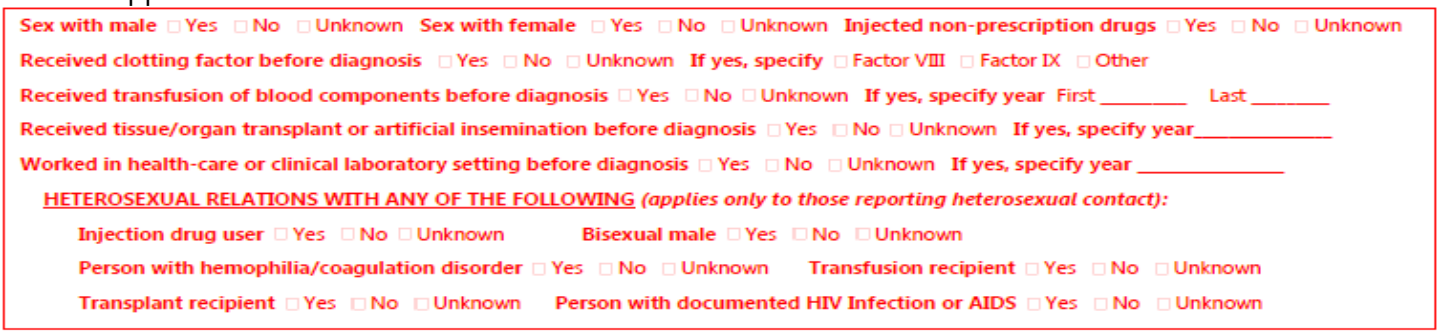
Person Completing Form (REQUIRED): Your Name
Facility (REQUIRED): Name of the agency or organization you work for
Phone (REQUIRED): Your phone number if there are additional questions or clarification needed

Section 2: Patient Demographics – Complete this section in its entirety. These data ensure that cases of HIV infection are counted only once, and allow the Program to describe HIV infection morbidity and mortality in New Mexico.

Patient Name_____ Date of Birth_____ Phone_____
(last name, first name, middle name)
Patient Alias_____ Patient Maiden Name_____
Current Address_____ City_____ County _____ State_____ Zip Code_____
Sex at Birth ☐Male ☐Female Current Gender ☐Male ☐Female ☐Transgender Male to Female (MTF) ☐Transgender Female to Male (FTM)
☐Unknown ☐Other gender (specify) _____
Is patient currently pregnant? ☐Yes ☐No ☐Unknown If yes, expected date of delivery _____
Ethnicity ☐Hispanic ☐Non-Hispanic Race ☐White ☐Native Am ☐African Am ☐Asian/Pacific Islander ☐Other_____
(Specify)
Social Security # _____ Country of Birth_____
Vital Status ☐Living ☐Deceased Date of Death _____ Place of Death_____
(City, State)

Patient Name (REQUIRED): Enter the full name of the patient you are reporting.
Date of Birth (REQUIRED): Enter the patient's date of birth (MM/DD/YYYY).
Phone (REQUIRED): Enter the patient's primary phone number. The Program does NOT contact patients directly. The phone number is used by NMDOH Disease Prevention personnel for patient education, referral to services, and to locate cases who may qualify for HIV Partner Services.
Patient Alias: List Alternate names, nicknames, or preferred names.
Patient Maiden Name: Any patient's maiden name or other names the patient has had in the past.
Current Address, City, County, State, Zip Code (REQUIRED): Enter patient's current address. If street address in not available, Postal Box information is acceptable.
Sex at birth (REQUIRED): Enter patient's sex assigned at birth
Current Gender: Enter the current gender identity of the patient, even if it is the same as the sex assigned at birth.
Is patient currently pregnant, expected date of delivery: Indicate whether the patient is currently pregnant. If yes, enter the expected delivery date.
Ethnicity (REQUIRED): Enter the patient's self-reported ethnicity, either Hispanic or Non-Hispanic.
Race (REQUIRED): Enter the patient's self- reported race. Select more than one race if applicable.
Social Security #: Enter the patient's full SSN if known, otherwise the last 4 digits are acceptable.
Country of Birth: Enter the country where the patient was born.
Vital Status (REQUIRED): Indicate whether the patient is currently living or deceased. If patient is deceased, enter the patient's **Date of Death (REQUIRED)** and the patient's **Place of Death (City, State)-(REQUIRED, if known).** These fields should be completed for all persons with HIV infection who are deceased, even if the death was not due to HIV-related causes.

Section 3: Risk Factors – Complete this section in its entirety. These data assist the Program to identify trends in HIV infection and guide the distribution of prevention resources. Select "Unknown" only when a patient interview/investigation does not provide an answer. Questions under "Heterosexual Relations with Any of the Following" should only be answered for patients who report any history of sexual contact with the opposite sex.



Sex with male (REQUIRED): Enter any history of sexual contact with a male, including oral sex or sexual assault. History of sexual contact can be reported by the patient or extracted from evidence in the patient's medical record.

Sex with female (REQUIRED): Enter any history of sexual contact with a female, including oral sex or sexual assault. History of sexual contact can be reported by the patient or extracted from evidence in the patient's medical record.

Injected non-prescription drugs (REQUIRED): Indicate whether the patient has any history of receiving an injection, either self-administered or given by another person, of a drug that was not prescribed by a physician for this person. This includes illicit drugs as well as prescription drugs (e.g., estrogen, testosterone, anabolic steroids, or human growth hormone) that were not prescribed for this person.

Received clotting factor before diagnosis (REQUIRED): Indicate whether the patient has any history of receiving clotting factor for hemophilia or coagulation disorder prior to their HIV diagnosis. "Coagulation disorder" or "hemophilia" refers only to a disorder of a clotting factor; factors are any of the circulating proteins named Factor I through Factor XII. These disorders include Hemophilia A and Von Willebrand's disease (Factor VIII disorders) and Hemophilia B (a Factor IX disorder).

Received transfusion of blood components before diagnosis (REQUIRED): Indicate whether the patient has any history of receiving a transfusion of blood or blood components , other than clotting factor, prior to their HIV diagnosis. Blood is defined as a circulating tissue composed of a fluid portion (plasma) with suspended formed elements (red blood cells, white blood cells, platelets). 'Blood components' that can be transfused, according to include erythrocytes, leukocytes, platelets, and plasma. If "Yes," specify the year of first and last transfusions before occurrence of patient's HIV diagnosis.

Received tissue/organ transplant or artificial insemination before diagnosis (REQUIRED): Indicate whether the patient has any history of receiving a tissue/organ transplant or artificial insemination prior to their HIV diagnosis. If "Yes," specify the year of the most recent tissue/organ transplant or artificial insemination before occurrence of patient's HIV diagnosis.

Worked in health-care or clinical laboratory setting before diagnosis (REQUIRED): Indicate whether the patient worked in a health-care or clinical laboratory setting prior to their HIV diagnosis. If "Yes," specify the most recent year in which the patient worked in a health-care or clinical laboratory setting prior to their HIV diagnosis.

Heterosexual Relations with any of the Following (REQUIRED-if applicable): This section should only be filled out for persons who indicate any history of sexual contact with persons of the opposite sex. For example, this section should not be completed for men having no history of sex with a female. Indicate whether the patient has any history of heterosexual contact with:

- A partner having any history of injection drug use
- A bi-sexual male (applies to females only)
- A person having any history of hemophilia/coagulation disorder
- A person having any history of receiving a blood transfusion
- A person having any history of receiving an organ transplant
- A person known to the patient to have HIV infection

These questions are about the patient's heterosexual *partners* so select "Yes" only if any of the patient's *partners* had any of these histories.

Section 4: HIV Diagnosis – Complete this section in its entirety, regardless of the date of the patient's HIV diagnosis or the patient's residence at the time of their diagnosis. These data assist the Program to de-duplicate case reports.

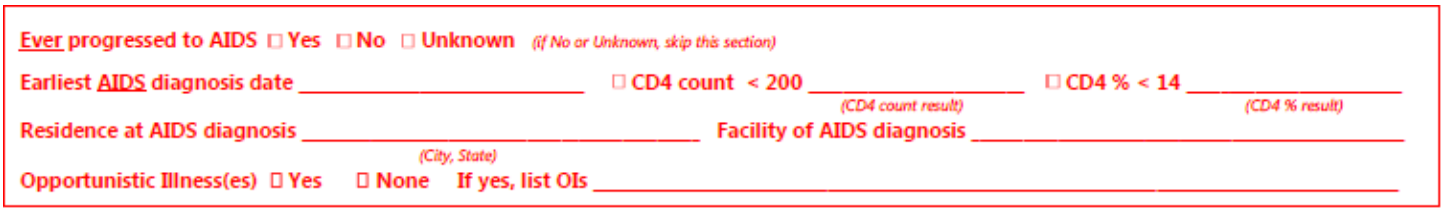
Earliest HIV diagnosis date (REQUIRED): Enter the specimen collection date of the first test which was used to diagnose the patient with HIV infection.

Test type(s) (REQUIRED): Indicate which type of test or tests were performed to confirm the patient's HIV diagnosis. If the earliest tests include a quantitative viral load, specify the number of copies/ml resulting from this test.

Residence at HIV diagnosis (REQUIRED): Enter the City and State of primary residence for the patient at the time of their initial HIV diagnosis.

Facility of HIV diagnosis: Enter the name of the facility at which the patient was initially diagnosed, if known.

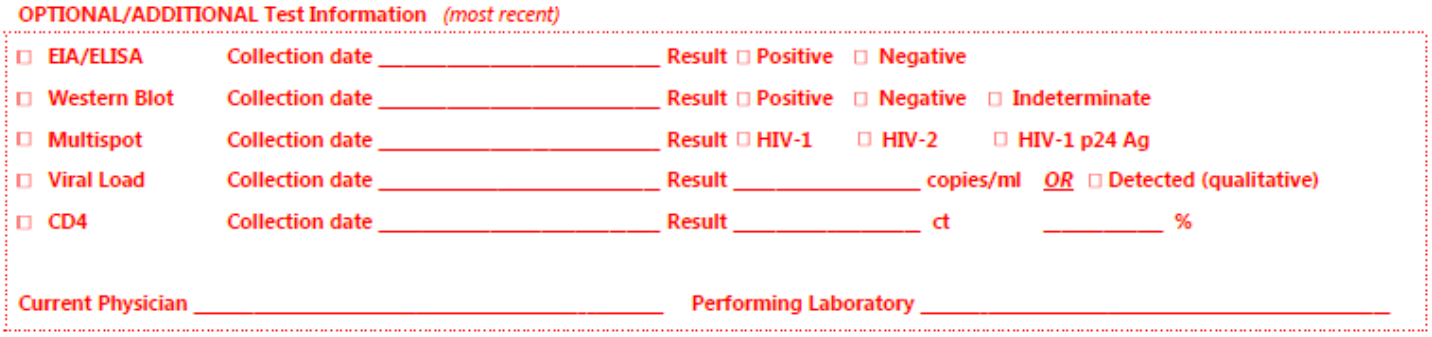
Section 5: AIDS diagnosis – Complete this section in its entirety only if the patient has ever progressed to HIV Stage 3 (AIDS) (i.e., the patient have ever had a CD4 count < 200, or a CD4 percent < 14%, OR has ever been diagnosed with any Opportunistic Infections). If the patient has NEVER progressed to HIV Stage 3 (AIDS), select "No", and skip the rest of this section as it is not applicable.



Earliest AIDS diagnosis date (REQUIRED): Enter the specimen collection date of CD4 count or percent which indicated the patient had progressed to HIV Stage 3 (AIDS) OR the date the person was diagnosed with an opportunistic infection.

- If HIV Stage 3 (AIDS) diagnosis was due to **immunologic test results** (CD4 count < 200 or CD4 percent < 14%), specify the test result, if known, in the space(s) provided
- If HIV Stage 3 (AIDS) diagnosis was due to **opportunistic illness**, select "Yes" and list the type(s) of opportunistic infections for which the patient has been diagnosed diagnosed.

Section 6: Optional/Additional Test Information – Complete this section only if HIV test data are known. Do NOT delay in submitting the Case Report Form if there are tests pending or the patient has not yet seen a provider to order tests.



*****If patient has a Positive EIA/ELISA and a Negative or Indeterminate Western Blot, please indicate this and note the patient should be re-tested in 2-4 weeks to rule out infection.**
Current Physician: Enter the name of the physician who is currently providing HIV care for this patient.
Performing Laboratory: Enter the name(s) of the laboratory at which the indicated tests were performed.