Houston Health Department / Texas Department of Health PHR 6/5 South

CONFIDENTIAL INFORMATION - HIV/AIDS REPORT

Mailing Address: 8000 N. Stadium Dr 4th Floor, Houston TX 77054. Ph: 832-393-5080. Confidential Fax: 832-393-5233

Reporting Facility: ____Date: ___________________

Person completing form: ____Contact Phone: _____________________________

PATIENT NAME (Last, F, MI) ____ **Date of Birth** _____/_____/_____

Street Address: ____City/State/Zip: _____________________________________

Phone:____ Sex: ________________Race /Ethnicity: ________________________

Social Security Number: ______–_____–_______ EC No. ____________________Country of Birth: _________________

Date of most recent visit: _____/_____/_____ Med. Rec. No. ____

Date of First Visit: _____/_____/_____ If Patient Expired: Date of Death: _____/_____/_____Place of Death: ________________

Other who can provide information (Hospital, Doctor, Clinic) ____

How patient became HIV-infected: (✓ all that applies)

___ Male who had sex with another male
___ Injection drug user
___ Sex with partner of opposite sex who is: (✓)
  ___ Injection drug user
  ___ Bisexual male
  ___ Hemophiliac
  ___ Person with HIV/AIDS
  ___ Other (specify) ___________________

____ Blood/blood product recipient, date _____/_____/_____
Facility where transfused ___________________________________
____ Treatment of hemophilia: Factor VIII (A) _____ Factor IX (B) _____
____ Occupational exposure (give details) ___________________________
____
____
____ No risk identified or patient denied all risk behavior
date patient was interviewed (Mo/Yr) _____/_____

Test	Results (+)	Collection Date	Test	Results (+)	Collection Date
HIV IFA			Geenius/Multispot HIV ½		
HIV WB			CD4 < 200 (cells/mm³)		
Rapid HIV			CD4 percent < 14		
HIV ½ EIA			HIV 1 PCR (VL Copies)		
HIV ½ Ag/Ab			HIV 1 PCR (NAAT)		

O.I./Neoplasm ________________________Method of Diagnosis _______________Date __________ Facility ______________

If patient is a woman:
(a) Patient receiving or referred for OB/GYN services: Yes____ No____ Unknown____
(b) Patient delivered live-born infant(s) after 1977: Yes____ No____ Unknown____
If Yes, and information is available, enter each child's, DOB, and hospital of delivery on back of this form.
(c) Patient currently pregnant: Yes____ No____ Due Date______________

Has this patient been notified of his/her HIV infection?

Yes____ No____ Unknown____

This patient's partners will be notified about their HIV **exposure and counseled by:**

Health Dept.____ Doctor/provider____ Patient____ Unknown____

This patient is receiving or has been referred for:

HIV related medical services: Yes____ No____ Unknown____

Substance abuse treatment services:

Yes____ No____ Not applicable____ Unknown____

Other significant information / TTH information

1) Previous positive HIV test:
Date: ______________ Where: _________________
2) Date of 1st positive HIV test: __________________
3) Ever had a negative HIV test: •Yes •No •Unk
4) Date of last negative HIV test: _________________
5) Number of negative tests within 24 months: ____
6) Ever taken ARV: •Yes •No •Unk

Name of ARV: ___________________________________
Start date: _______________End date: ______________
Co-infections: ____________________________________

Revised 03/27/2024