National Surveillance Unit, National Epidemiology Branch,
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HIV Confidential Reporting Form (CRF)

REASON FOR SUBMITTING CONFIDENTIAL REPORTING FORM		
◯ Initial HIV Diagnosis	◯ Pregnancy of HIV positive woman	◯ Risk History Update
◯ Advanced HIV Diagnosis	◯ ART Initiation	◯ Migration
◯ AIDS Diagnosis	◯ Treatment Regimen Change	
◯ Death Notification	◯ Viral suppression	

PATIENT'S DEMOGRAPHICS	
Patient's ID Type: ◯Driver's License ◯TRN ◯Passport ◯ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's Maiden Name (if applicable):	
Sex Assigned at Birth: ◯ Male ◯ Female	Gender: ◯ Male ◯ Female ◯ FTM ◯ MTF ◯ Other
Date of Birth: *DD/MM/YYYY*	Age:
Medical Record Number:	Is patient employed? ◯ Yes ◯ No
Occupation:	

Marital Status:

◯ Married	◯ Visiting union	◯ Widowed	◯ Separated
◯ Common law	◯ Single	◯ Divorced	◯ Other (specify):

Is patient homeless? ◯ Yes ◯ No

Country of Residence:	Parish (Jamaica):	Community:

House Number, Street Name:

Landmark or directions to address:

Phone Number:	Email Address:

Highest level of Education completed:

◯ No formal schooling	◯ Primary/All Age/Preparatory	◯ Tertiary /Post-secondary	◯ Other
◯ Basic	◯ Secondary/High School	◯ Vocational Skills Training	

Number of children under 15 years of age:

Was client/patient/person ever deported? ◯ Yes ◯ No

If yes, which country was the person deported from?	If yes, date deported (*MM/YYYY*):

MOTHER'S NAME:

NEXT OF KIN:

First Name:	Last Name:
Address: Lot/ Street/Community/Parish:	
Phone number of Next of Kin:	Email address of Next of Kin:

Relationship to the Patient:

◯ Wife	◯ Father	◯ Sister	◯ Aunt	◯ Cousin
◯ Husband	◯ Son	◯ Brother	◯ Grandmother	◯ Friend
◯ Mother	◯ Daughter	◯ Uncle	◯ Grandfather	◯ Other

PATIENT'S RISK HISTORY						
	Ever			12 Months		
Date of Assessment: *DD/MM/YYYY*	Yes	No	Unknown	Yes	No	Unknown
Was patient incarcerated/ in prison?	○	○	○	○	○	○
Has patient used crack/cocaine?	○	○	○	○	○	○
Has patient used intravenous drugs?	○	○	○	○	○	○
Has patient had a sexually transmitted infection?	○	○	○	○	○	○
Has patient had genital ulcers/sores?	○	○	○	○	○	○
Has patient had sex with a commercial sex worker?	○	○	○	○	○	○
Has patient been a commercial sex worker?	○	○	○	○	○	○
Has patient had unprotected anal sex?	○	○	○	○	○	○
Has patient had multiple sex partners?	○	○	○	○	○	○
Was patient a victim of sexual assault?	○	○	○	○	○	○
Has patient had sex with a known person living with HIV {PLHIV)?	○	○	○	○	○	○
Has patient had transactional sex?	○	○	○	○	○	○
Did patient have perinatal exposure to HIV?	○	○	○	○	○	○
Has patient received a blood transfusion?	○	○	○	○	○	○

Blood Transfusion Date: *DD/MM/YYYY*	
Hospital where blood transfusion was received:	

STATUS OF PATIENT			
Date of Assessment: *DD/MM/YYYY*	Yes	No	Unknown
Does patient have generalised lymphadenopathy?	○	○	○
Does patient have generalised dermatitis?	○	○	○
Has patient had shingles?	○	○	○
Has patient experienced persistent cough for more than 4 weeks?	○	○	○
Has patient experienced fever for more than 1 month?	○	○	○
Does patient have chronic diarrhoea?	○	○	○
Has patient experienced recurrent pneumonia?	○	○	○
Does patient have Tuberculosis?	○	○	○
Pulmonary tuberculosis	○	○	○
Extra-pulmonary/disseminated tuberculosis	○	○	○
Does patient have central nervous system {CNS) disease/involvement?	○	○	○
Has patient had unintentional weight loss of more than 10% of body weight?	○	○	○
Has patient had Kaposi's Sarcoma?	○	○	○
Has patient been diagnosed with Pneumocystis carinii {jiroveci) pneumonia {PCP)?	○	○	○
Has patient had oral candidiasis?	○	○	○
Has patient had oesophageal candidiasis	○	○	○
Has patient had vaginal candidiasis?	○	○	○
Has patient had invasive cervical cancer?	○	○	○
Has patient had severe bacterial infection?	○	○	○

If Yes, please specify:

Other clinical issues:

Post-test counselling:		
Patient received post-test counselling: ◯ Yes ◯ No	Performed by: ---------- (Enter Provider's Name)	Date of post-test counselling: DD/MM/YYYY

HIV SCREENING TEST

Date of Screening Test: DD/MM/YYYY

HIV Screening Test Type:

◯ Determine	◯ Colloidal Gold	◯ OraQuick	◯ Other {please specify)
◯ Uni-Gold	◯ ELISA	◯ Nucleic acid {NAT, PCR; viral load)	

HIV Screening Test Results:

◯ Positive	◯ Negative	◯ Indeterminate

How was test initiated?

◯ Provider-initiated	◯ Self-referral

Where was the test done?

◯ Antenatal Clinic	◯ Hospital	◯ Other Public Clinic	◯ STI Clinic
◯ Blood Bank	◯ Insurance	◯ Private Antenatal	◯ Private Pharmacy
◯ Home-based/self-test	◯ Mobile Clinic/Outreach	◯ Private Doctor	◯ Private Lab
Other {please specify): ----------			

Date of Confirmatory Test: DD/MM/YYYY

Confirmatory HIV Test Type?

◯ Determine	◯ Colloidal Gold	◯ OraQuick	◯ Other {please specify)
◯ Uni-Gold	◯ ELISA	◯ Nucleic acid {NAT, PCR; viral load)	

Confirmatory HIV Test Result:

◯ Positive	◯ Negative	◯ Indeterminate

Laboratory where confirmatory HIV test performed:

◯ National Public Health Laboratory	◯ University Hospital of the West Indies	◯ Other {Specify):

BEHAVIOURAL PRACTICE OF PATIENT

With whom does patient have sex?

◯ Men only	◯ Women only
◯ Both men and women	◯ Refuses to answer

Key and vulnerable population characteristics of patient {Check all that apply):

◯ Men who have sex with men	◯ Prisoner/Prison history	◯ Intravenous Drug User
◯ Commercial sex worker	◯ Transgender	

Transmission Category:

◯ Sexual	◯ Blood Transfusion	◯ Haemophiliac
◯ IV Drug Use	◯ Vertical	

Patient's Sexual Contacts: Please complete contact listing on page 5.

Was this patient transferred from another treatment site?

◯ Yes ◯ No

Contact Tracing:

◯ Trace	◯ Do not contact trace	◯ Contact partners only

Detailed Test Results		
CD4 Count (cells/µl):	Date of CD4 Count: *DD/MM/YYYY*	CD4/CD8 Ratio:
Viral Load (copies/ml):	Date viral load sample taken *DD/MM/YYYY*	
Has patient ever taken antiretroviral medications (ARVs)? ◯ Yes ◯ No	ARV Start Date *DD/MM/YYYY*	
Has patient ever taken pre-exposure prophylaxis (PrEP)? ◯ Yes ◯ No	If yes, what is the last date patient took (PrEP) *DD/MM/YYYY*	
Has patient ever taken post-exposure prophylaxis (PEP)? ◯ Yes ◯ No	If yes, what is the last date patient took (PEP) *DD/MM/YYYY*	
Other (Specify):		

ARV Line:

◯First line	◯Third line	◯Unknown
◯Second line	◯Salvage therapy	

Patient's Current Category:

◯ HIV	◯ Advanced HIV
◯ AIDS	◯ AIDS Death

Date of Onset of Symptoms: *DD/MM/YYYY*	Date diagnosed as Advanced HIV: *DD/MM/YYYY*
Date diagnosed as AIDS: *DD/MM/YYYY*	Date of death: *DD/MM/YYYY*

Cause of death:

ii.	iii.	iiii.
Immediate cause	Intermediate cause	Underlying cause

FOR PREGNANT WOMEN ONLY		
Is Patient Pregnant: ◯ Yes ◯ Unsure	Last Menstrual Period: *DD/MM/YYYY*	
Gravida:	Parity:	
Estimated Gestational Age ---------- weeks	Estimated Date of Delivery: *DD/MM/YYYY*	
Clinic Medical Record Number:	Clinic Site:	Parish:

Status of Referral

◯ Not Referred	◯Referred	◯Refused Referral

Facility Referred To:	Date of First Antenatal Referral Appointment: *DD/MM/YYYY*

PHYSICIAN ATTENDING TO PATIENT
Name of Patient's Doctor:
Hospital/Clinic/Doctor's Office Address:
Phone Number:

Source(s) of information:

◯Patient	◯Next of Kin	◯Other
◯Medical record	◯Relative	

Comments:

Investigator's Details		
First Name:	Last Name	
Professional Group:		
Phone number:	Email Address:	
Name of Institution:		
Parish:	Community:	
Office Number/Street Name:		
Health Region: ◯ SERHA ◯ NERHA ◯ SRHA ◯ WRHA		
Date Investigation Completed: *DD/MM/YYYY*	Investigator's Signature:	
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*

Patient's Sexual Contacts:

First Name (Include alias)	Last Name	Sex (M/F)	Relation	Address (include Parish)	Phone Number

Patient's Name: _____ Medical Record Number: ----------

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Definitions and Notes

- **Antiretroviral (ARV) Line**: Indicate ARV line patient is currently on/or last took - 1st, 2nd, 3rd, salvage therapy
- **Candidiasis**: Fungal infection with Candida spp that can be oral, oesophageal, and/or vaginal
- **Cause of death**: Recorded as i. Immediate, ii. Intermediate or iii. underlying causes.
- **Central Nervous System (CNS) Involvement**: Unexplained recent onset of seizures, dementia, toxoplasmosis, cytomegalovirus (CMV), cryptococcus, encephalopathy
- **Chronic Herpes Simplex**: Reported history of recurrent genital ulcer, blisters or crusts
- **Clinical Status**: Diagnosis should be confirmed by a physician
- **Commercial sex worker (CSW)**: Exchange of sex for cash as a main source of income
- **Cough (> 4 weeks)**: May be intermittent or persistent, productive or not
- **Date of Assessment**: Date on which assessment is being done for risk history or clinical status
- **Dermatitis**: Unexplained rash to multiple parts of the body
- **Diarrhoea (> 1 month)**: Three (3) or more watery stools in a 24-hour period
- **Education**: No formal schooling, Basic, Primary/All Age, Secondary/High School, Tertiary, Skills training, Other (specify)
- **Fever (> 1 month)**: On and off temperatures of 100.4° F (38° C) or more than is temporarily alleviated by antipyretics or other medications
- **Generalised Lymphadenopathy**: Two or more sites with enlarged lymph nodes
- **Invasive Cervical Cancer**: History of or current cytological diagnosis of cervical cancer that has spread beyond the cervix – Stage 1a or greater
- **Kaposi's Sarcoma (KS)**: HIV-related Kaposi's sarcoma
- **Marital Status**: Married, common law, visiting union, single
- **Multiple Partners**: Persons who report having sex with more than one person within the past 12 months
- **PCP/PJP**: Current or past diagnosis of Pneumocystis carinii (jiroveci) pneumonia
- **Recurrent Pneumonia**: Repeated lower respiratory tract infections; Two or more episodes within a 1-year period
- **Severe Bacterial Infection**: Infection at any site of the body for which the patients had to be hospitalised for any period of time for treatment
- **Sexual Assault**: Anal or vaginal intercourse without consent; incident involved intimidation or threat or fear of violence
- **Shingles**: Recent or current diagnosis of the skin infection caused by the Varicella zoster virus
- **Transactional Sex**: Exchange of sex for food, goods or cash (but not as main source of income)
- **Transfer**: Indicate if the patient transferred in from another treatment site or private physician
- **Tuberculosis**: Confirmed TB case; If Yes: Pulmonary/Extra Pulmonary/Disseminated – select the appropriate condition(s)
- **Weight Loss (> 10%)**: Unintentional weight loss, i.e. patient has made no direct efforts to lose weight e.g., exercise or dieting

Patient's Name: _____ Medical Record Number: ----------Updated