HAHSTA

Testing and Case Report Form

QUICK REFERENCE GUIDE

DC | HEALTH

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HIV/AIDS, HEPATITIS, STD AND TB ADMINISTRATION
899 NORTH CAPITOL ST. NE 4TH FLOOR
WASHINGTON, DC 20002

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Introduction

The District of Columbia Municipal Regulations (DCMR Chapter 22-B2) authorizes the District of Columbia Department of Health to conduct public health surveillance and disease investigations as necessary for public health purposes and maintain strict policies and procedures to protect and secure sensitive information. In addition, the Health Insurance Portability and Accountability Act of 1996[1,2] contains a clause that allows the release of personal identifying and private health information to health departments without the need for the patient's consent. Licensed health care providers and laboratories are expected to abide by regulations that describe the diseases/conditions and time frames for reporting to the DC Department of Health. Timely responses are important toward efforts for disease interruption services provided by our Disease Intervention Specialists (DIS), including referral or linkage to care and treatment, risk assessment, prevention counseling, and partner services (prevention, testing, and treatment).

Comprehensive and timely data reporting also aids in prevention initiatives by allowing the Department of Health to understand populations getting tested, identifying groups at high risk for HIV/STI infection and for the development of new programs designed to properly provide HIV/STI prevention services. HIV prevention initiatives rely on the reporting of comprehensive data elements from all testing partners in order to effectively measure the success of targeted testing campaigns and ensuring that people infected with HIV are aware of their status as soon as possible and linked into appropriate care.

Investigators need to be able to review medical charts and disease history, at minimum, need to verify legal name, aliases, date of birth, addresses, phone numbers, race/ethnicity, gender identity and other physical descriptions (i.e., height, build, complexion, hair color, tattoos, and etc.), signs and symptoms, treatment, gender of sex partners, substance abuse and mental health issues, and prevention modalities previously used. This information helps to prioritize initiation of prevention and intervention services.

Your cooperation and partnership in public health is vital to the success of our efforts in harm reduction and disease interruption. We are willing to design policies and procedures with you that will allow expeditious investigations by our Disease Investigators and Disease Intervention Specialists.

Results of our disease surveillance efforts are available in our Annual Epidemiology and Surveillance Report at:

https://dchealth.dc.gov/service/hiv-reports-and-publications

If you have questions or concerns, please feel free to reach out to the Strategic Information Division at the HIV/AIDS, Hepatitis, STD and TB Administration within the District of Columbia Department of Health.

The Government of the District of Columbia
Department of Health
Strategic Information Division
899 North Capitol Street NE, 4th Floor
Washington, DC 20002
Phone: 202-671-4900

[1] https://www.hhs.gov/sites/default/files/privacysummary.pdf
[2] https://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm

Reporting Regulations

The DC Municipal Regulations (DCMR) requires providers or person's in charge of a reportable disease/condition to notify the health department of a disease. Chapter 22, B201 of the DCMR contains the regulations for communicable and reportable diseases. HIV/AIDS, viral hepatitis, sexually transmitted infections (syphilis, gonorrhea, and chlamydia), and tuberculosis are required to be reported within 48 hours of diagnosis. Upon receiving notification of an infection, the health department shall make any investigation that is deemed necessary for the purposes of determining the source of infection and the nature of treatment. To facilitate, the investigation, any entity providing health or medical services shall make medical records and histories available for review. Information collected is used for statistical, public health, epidemiological, and surveillance purposes. The health department's collection of personal identifying and private health information is solely for public health purposes and will not be disclosed for other purposes without the individual's written consent or a court order.

For more information about reporting requirements, please visit:

https://www.dcregs.dc.gov/Common/DCMR/RuleDetail.aspx?RuleId=R0020670

Prevention Testing Instructions for Completion

The HAHSTA Case and Testing Report Form should be used to report all test events that are conducted using funds from the Division of Prevention and Intervention Services at HAHSTA. This includes all negative and positive test events. For any questions and issues surrounding reporting, please contact your assigned project officer.

Detailed instructions for completing the report:

- The fields on this form reflect data requirements as described in the most current NHME Data Variable Set.

- Four data fields are mandatory for a valid testing event: Session Date, Program Announcement, Agency ID or CBO agency ID as applicable, and Jurisdiction (populated automatically in EvaluationWeb).

- There are three different response formats that you will use to record data: (1) text boxes, (2) drop down lists and (3) fill-in ovals. Text boxes are used to write in information (codes and dates). Drop down lists and fill-in ovals are used to select only one response, unless otherwise indicated by the question.

- Depending on your jurisdiction you will either write in the name or the identification number for the Agency and Site. In these instances you will want to follow the convention of your jurisdiction. Do not write both the identification number and name for these fields.

- For client county of residence, report the three-digit FIPS code for the county, not the county name.

Case Report Instructions for Completion

The HAHSTA Testing and Case Report Form should be completed in its entirety to report all new cases of HIV/AIDS, Hepatitis, Sexually Transmitted Infections, and Tuberculosis. The form is divided into ten major sections with each section including information required to be reported to the Center for Disease Control and Prevention. All new diagnoses are required to be reported within 48 hours of confirmation. This form is available electronically, as a fillable PDF document, or as a standard PDF file. For any questions and issues surrounding reporting, please contact the Strategic Information Division of HAHSTA via email at HAHSTA.CaseReport@dc.gov or via phone at 202-671-4900.

The HAHSTA Testing and Case Report Form can be found at the link below:

https://redcap.doh.dc.gov/surveys/index.php/surveys/?s=7KLXPD3PD9

Form Handling

The HAHSTA Case Report Form should be sent to the District of Columbia Department of Health within 48 hours of diagnosis or suspicion of infection. Forms can be delivered in three ways:

1) Electronic transmission- upon completion of the electronic form, it is transferred to the health department.
2) Facsimile transmission -to secured line ONLY at 202-727-3345. Sending forms to any other number is **NOT ACCEPTABLE**.
3) Mail -Forms may be sent U.S. Postal Service in sealed doubled envelopes marked **CONFIDENTIAL** to the following address (do not indicate any specific diseases on the outside of the envelope):

The Government of the District of Columbia
Department of Health
Strategic Information Division
899 North Capitol Street NE, 4th Floor
Washington, DC 20002

4) Hand Delivered- Forms can be hand delivered to the above address during regular business hours (8:15AM to 4:45PM).

It is not acceptable to e-mail private health information.

HAHSTA Testing and Case Report Form Quick Reference

Section 1: Testing and Case Report Form		
Question	**Description**	**Example**
Date Completed	Enter the date that the form was completed. The date will automatically default to the current date.	MM/DD/YYYY 12/01/2018
Program	• **Prevention Testing Program:** Testing conducted through funding from the Prevention and Intervention Services Division of HAHSTA • **Youth STD Services Program:** Testing conducted through funding from the Youth STD Services Program of HAHSTA • **School Based Screening Program:** Testing conducted through funding from the School Based Screening Program of HAHSTA • **Tuberculosis Case Reporting Only:** All diagnosed cases of TB occurring without co-infection with HIV, Hepatitis, or STD in DC • Co-infected cases should be submitted as blank/not applicable • **Blank/ Not Applicable:** All potentially newly diagnosed cases of HIV, Hepatitis, or STD, or TB occurring in DC	Prevention Testing Program

Section 2: Health Provider Information		
Agency Name	**Prevention Testing Only** Select the name of the agency completing the form	La Clinica del Pueblo
Site Name	**Prevention Testing Only** If your agency has more than one site, use this field to select the specific site conducting the testing.	Columbia Heights Metro
Reporting Facility Name	Enter the name of the facility, practice, or organization reporting the case to the health department.	La Clinica del Pueblo
Other Reporting Facility	If "Other" is selected for Reporting Facility Name, the facility name must be entered in Other Reporting Facility Name.	Dr. Smith Private Healthcare Office
Person Completing Form	Enter the first and last name of the person completing the form.	John Doe
Person Completing Form Email	Enter the email of the individual completing the form.	Jon.Doe@healthcarefacility.com
Phone	Enter the telephone number of the person completing the form	202-555-2236
Fax	Enter the fax number of the person completing the form.	202-555-2245
Session Date	**Prevention Testing Only** Enter the date the testing session took place.	MM/DD/YYYY 12/01/2018
Program Announcement	**Prevention Testing Only** Select the program announcement your agency is funded under for this testing event.	HCA
Service Type	Indicate the type of service type that was provided for the client.	Inpatient
Street Address	Enter the street address of your facility.	1234 K Street NW
State	Enter the facility's state.	District of Columbia
City	Enter the facility's city.	Washington
County/Ward	Enter the facility's county or ward. Ward will only become available if you indicate "District of Columbia" in the "State" field.	1

Country	Enter the facility's country from the drop down menu.	United States
Zip Code	Enter the facility's zip code.	22202
Section 3: Client Identifiers and Demographics		
Last Name	The surname given at birth.	Doe
First Name	The first name given at birth.	John
Date of Birth	The date in which the patient was born.	01/15/1990 (MM/DD/YYYY)
Social Security Number	The entire or partial social security number of the patient.	867-53-1234
Client ID	**Prevention Testing Only** Indicate the client's ID if applicable. This could be any type of internal identify that your facility may use.	SMJ5
Medical Record Number	Enter the medical record used for the client.	SM9876
Sex Assigned at Birth	Enter the client's sex that was assigned at birth.	Female
Current Gender Identity	Enter the current identity as reported by the client.	Male
Ethnicity	Enter the client's reported ethnicity. If client refuses to answer or the ethnicity is unknown, select "Unknown."	Hispanic or Latino
Race	**White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Black or African American** A person having origins in any of the Black racial groups of Africa. **American Indian or Alaska Native** A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.	White

	Asian A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Other** A person having multiple origins or race	
Additional Race	Select as many races as are reported by the patient.	Black
If female, pregnant?	Indicate the pregnancy status if your client's sex assigned at birth is female. This field will only populate if the client indicates that they are "female" for "Sex assigned at birth.	Don't know
If pregnant, in care?	Indicate if the pregnant client is in care. This field will only become available if select "Yes" in the "If female, pregnant" field.	Declined to Answer

Section 4: Patient Contact Information		
Address Type	**Residential** The address where the patient resides. **Correctional** Check this box if the patient is currently residing within a correctional facility. **Foster Home** Check this box if the patient is residing in a foster home. **Postal** Check this box if a postal box address is given. **Shelter** Check this box if the patient is currently residing in a shelter home. **Temporary** Check this box if the address given is not a permanent address. (Ex. patient living with friend, away at college or with a family member) **Bad/Invalid Address** The address provided by the patient does not exist. The DC Master Address Repository can be searched for valid District of Columbia addresses: http://dcatlas.dcgis.dc.gov/mar	Postal
Current Street Address	The number and name of the street where the patient resides.	1111 Main Street NW
Apartment Number	The apartment number where the patient resides.	Apt. #3
State	Enter the facility's state.	District of Columbia, Virginia, etc.

City	The city where the patient resides.	Washington
County/Ward	Enter the facility's county or ward. Ward will only become available if you indicate "District of Columbia" in the "State" field.	1
Zip Code	The zip code where the patient resides.	21121
Home Phone Number	Home telephone number of the patient	202-555-2222
Mobile Phone Number	Mobile telephone number of the patient	202-555-6654
Preferred Phone Number	Patient's preferred contact telephone number	Home Number
Email Address	Patient's email address	John.Doe@healthcare.com
Section 5: Emergency Contact Name		
Emergency Contact Name	Indicate the name of the client's emergency contact.	Jane Doe
Emergency Contact Phone	Enter the phone number for the client's emergency contact.	202-555-6544
Emergency Contact Relationship	Indicate the relationship for client's emergency contact.	Spouse
Section 6: Risk History		
Did Client Complete a Behavior Risk Profile?	**Prevention Testing Only** Indicate if the patient completed a Behavior Risk Profile.	Yes
Sex with male	Indicate if the client had sex with a male.	Yes
Who is an injection drug user (IDU)?	Indicate if the client had sex with a male and is an injection drug user (IDU).	No
Who is Human Immunodeficiency Virus (HIV) positive	Indicate if the client had sex with a male and who is HIV positive.	Yes
Who has received any of the following:	Indicate if the client had sex with a male who had a transplant, transfusion, and/or hemophilia/coagulation disorder. Check all that apply. If	Transfusion

	none apply or unknown, leave this section blank.	
Sex with female	Indicate if the client had sex with a female.	Declined to answer
Who is an injection drug user (IDU)?	Indicate if the client had sex with a female and is an injection drug user (IDU).	No
Who is Human Immunodeficiency Virus (HIV) positive	Indicate if the client had sex with a female and who is HIV positive.	Yes
Who has received any of the following:	Indicate if the client had sex with a female who had a transplant, transfusion, and/or hemophilia/coagulation disorder. Check all that apply. If none apply or unknown, leave this section blank.	Transfusion
Sex with a person who is transgender	Indicate if the client had sex with a person who is transgender.	Yes
Who is an injection drug user (IDU)?	Indicate if the client had sex with a transgender and is an injection drug user (IDU).	No
Who is Human Immunodeficiency Virus (HIV) positive	Indicate if the client had sex with a transgender and who is HIV positive.	Yes
Who has received any of the following:	Indicate if the client had sex with a transgender who had a transplant, transfusion, and/or hemophilia/coagulation disorder. Check all that apply. If none apply or unknown, leave this section blank.	Transfusion

Used injected non-prescription drugs?	Indicate if the client used injected non-prescription drugs.	Yes
Share drug injection equipment	Indicate if the client shared drug injection equipment.	Yes
Worked in a healthcare or clinical laboratory setting?	Indicate if the client worked in a healthcare or clinical laboratory setting.	Yes
If yes, specify occupation and setting	If the client indicates that they worked in a healthcare setting, indicate the client's healthcare occupation from the drop down menu.	Paramedic
Setting	Indicate the type of setting if "Other" was selected in "Yes, specify occupation and setting."	Clinical, law enforcement, etc.
Was the Patient Perinatal Exposed (<18 months old) to the disease being reported?	Indicate if the client was perinatal exposed to the disease being reported.	No
Was the client linked to social and behavioral support services?	**Prevention Testing Only** Indicate if the client was linked to social behavioral support services.	Yes
Section 7: Client History		
Date of exam/test	Indicate the date of the exam/test/	01/05/2018 (MM/DD/YYYY)
Reason for exam/test	Enter the reason the client was examined/tested	Painful urination
Previous HIV Test?	**Prevention Testing Only** Indicate if the client had a previous HIV test.	Yes
If yes, what is the client's result?	**Prevention Testing Only** Indicate the client's result from the drop down menu. **This field will only become available if you indicated "yes" on "Previous HIV test."**	Self-Reported Negative

Was client referred to STI testing?	**Prevention Testing Only** Indicate if the client was referred to STI testing.	Yes
Was client referred to STI screening?	**Prevention Testing Only** Indicate if the client was referred to HIV screening.	Yes
Section 8: Prevention Testing Only: Testing Event Reporting		
Test Type	Indicate the test type from the drop down menu.	Gonorrhea
If "other" please specify	Indicate the "other" test type. **This field will only become available if you indicated "Other" on "Test Type."**	Hepatitis A
Sample Date	Indicate the date the sample was acquired (e.g., blood sample, culture, etc.)	11/22/2018 (MM/DD/YYYY)
Worker ID	Indicate worker ID that the facility has assigned to the individual who is preforming the tests. This information could the name of the individual performing the tests or an identification code for the individual performing the test.	John Smith, JSmith, JS764, etc.
Test Election	Indicate the test election from the drop down menu.	Confidential
Test Technology	Indicate the test technology from the drop down menu.	NAAT/RNA Test
Other, please specify	Indicate the "other" test technology. **This field will only become available if you indicated "Other" in the "Test Technology" field.**	Dark Field
Test Result	Indicate the client's test result.	Positive
Results Provided	Indicate if the client was informed of their test results.	Yes
If results NOT provided, why?	Indicate why the client was not notified of their results from the drop down menu. **This field will**	Declined Notification

	only become available if you selected "No" in the "Results Provided" field.	
Results NOT provided Other, specify	Indicate why the results not provided in this field. **This field will only become available if you selected "Other" in the "If Results NOT provided, why?"**	Patient left without notifying healthcare staff.
Prevention Test 2	**This will only become available if the test result is "Positive." If there are no other Prevention Tests, leave this section blank and move onto the "PrEP Knowledge and Utilization" section.**	
Section 9: PrEP Knowledge and Utilization		
Has Client ever heard of Pre-Exposure Prophylaxis (PrEP)?	Indicate if the patient has ever heard of Pre-Exposure Prophylaxis (PrEP).	Yes, confirmed
Is the Client currently taking daily PrEP medication?	Indicate if the client is currently taking PrEP medication.	Yes
Has the client used PrEP anytime in the last 12 months?	Indicate if the client has used PrEP anytime in the last 12 months.	Yes
Section 10: Disease Reporting		
Reporting Diseases	Indicate the disease that you are reporting (Select all that apply).	Gonorrhea, HIV, and Syphilis
Was the patient notified that they may be contacted by DOH Disease Intervention Specialists (DIS)?	Indicate if the patient was notified that they may be contacted by DOH Disease Intervention Specialists from the drop down menu.	Yes
Chlamydia		
Positive specimen site (check all that apply)	The site of infection for chlamydia.	Urethra
Other positive specimen site	The site of infection for chlamydia, if not already indicated	Cervix
Was treatment provided?	Indicate the patient's treatment status using the drop down menu.	Yes

Treatment	The name of the treatment regimen prescribed to the patient.	Azithromycin 1g
Date Treated	The date the patient received medication/treatment services.	5/16/2018 (MM/DD/YYYY)
Other Treatment	The name of "Other" treatment regimen prescribed to the patient, if not previously indicated. **This field will only become available if you indicated "Other" in "Treatment."**	
Date Treated	The date the patient received the "Other" medication/treatment services.	5/16/2018 (MM/DD/YYYY)
If referred for treatment, where?	The facility/provider the patient was referred to for treatment services. **This field will only become available if you selected "Referred Elsewhere" in "Was treatment provided."**	DC Health and Wellness Clinic
Was the patient offered Chlamydia-expedited partner therapy (EPT)?	The patient was offered Chlamydia expedited partner therapy (chlamydia treatment for their sexual partners)	Yes
If yes, number of prescriptions/medications provided	The number of medications/prescriptions the patient was given for their partners.	2
Gonorrhea		
Positive specimen site (check all that apply)	The site of infection for gonorrhea.	Rectum
Other positive specimen site	The name of the treatment regimen prescribed to the patient, if not previously indicated. **This field will only become available if you selected "Other" in "Positive specimen site."**	Cervix
Was treatment provided?	Indicate the patient's treatment status using the drop down menu.	Yes

Treatment	The name of the treatment regimen prescribed to the patient.	Ceftriaxone 250mg IM AND Azithromycin 1g
Date Treated	The date the patient received medication/treatment services.	5/16/2018 (MM/DD/YYYY)
Treatment Other	The name of the treatment regimen prescribed to the patient, if not previously indicated. **This field will only become available if you selected "Other" in "Treatment."**	
Date Treated	The date the patient received the "other" medication/treatment services.	4/4/2014
If referred for treatment, where?	The facility/provider the patient was referred to for treatment services. **This field will only become available if you selected "Referred Elsewhere" in "Treatment."**	DC Health and Wellness Clinic
Was the patient offered Gonorrhea-expedited partner therapy (EPT)?	The patient was offered Gonorrhea expedited partner therapy (gonorrhea treatment for their sexual partners)	Yes
If yes, number of prescriptions/medications provided	The number of medications/prescriptions the patient was given for their partners.	3
Hepatitis B		
Diagnosis type	The current or past status of Hepatitis B occurrence.	Past
Date Diagnosed	Date patient received positive confirmatory test results.	05/10/2018
Vaccinated?	Has the patient been vaccinated for Hepatitis B	Yes or NO
Describe symptoms if any:	The physical or mental feature that is appears apparent on the patient indicating a condition of Hepatitis B.	Abdominal pain

Positive HBV-related Test	**HBsAg**: Hepatitis B Surface Antigen Test **HBsAb**: Hepatitis B Surface Antibody Test **HBcAb Total**: Hepatitis B Core Total Antibodies Test **HBcAb IgM**: Hepatitis B Core Antibodies Immunoglobulin M Test	HBsAg
Test sample date	The date the sample was collected	05/10/2018 (MM/DD/YYYY)
Hepatitis C		
Diagnosis type	The current or past status of Hepatitis C occurrence.	Current
Date Diagnosed	Date patient received positive confirmatory test results.	05/10/2018
Describe symptoms if any:	The physical or mental feature that is appears apparent on the patient indicating a condition of Hepatitis C.	Abnormalities in urine
Positive HCV-related Test	**Antibody HCV Screening Test**: A test used to detect antibodies to the hepatitis C virus, indicating exposure was administered. **Antibody HCV RIBA**: A confirmation test for the hepatitis C antibody was administered. **Antibody HCV RNA**: A qualitative test used to distinguish between a current or past HCV infection was administered.	Antibody HCV RNA
Test sample date	**The date the sample was collected**	05/10/2018 (MM/DD/YYYY)
HIV		
Was the diagnosis documented by a physician	The patient had the diagnosis of HIV documented by a physician at your facility.	Yes
Date Diagnosed	Date patient received positive confirmatory test results.	05/10/2018

Positive HIV-related Test	**HIV-1 IA (EIA or Other)**: HIV-1 Antibody Test **HIV-1/2 IA (EIA or Other)**: HIV-1/2 Antibody Test **HIV-2 IA (EIA or Other)**: HIV-2 Antibody Test **HIV-1/2 Ag/Ab (Fourth Generation)**: HIV 1/2 Antigen/Antibodies Test **HIV-1/2 Type-Differentiating Immunoassay**: HIV-1/2 Antibody Confirmation and Differentiation Test **HIV-1 RNA/DNA NAAT (Qualitative)**: HIV-1 RNA/DNA Qualitative Nucleic Acid Amplification Test **HIV-1 RNA/DNA NAAT (Quantitative Viral Load)**: HIV-1 RNA/DNA Quantitative Nucleic Acid Amplification Test	HIV-1/2 Ag/Ab
Test Sample Date	Indicate the test sample date	12/04/2018 (MM/DD/YYYY)
HIV-1/2 Type-Differentiating Immunoassay		
HIV Type Differentiating Result	Indicate the HIV Type Differentiating Result from the drop down menu.	HIV-1
HIV-1 RNA/DNA NAAT (Quantitative Viral Load)		
Viral Load Result	If HIV-1 RNA/DNA NAAT (Quantitative Viral Load) is selected, list the results of the test	1.43
Viral Load Test Units	If HIV-1 RNA/DNA NAAT (Quantitative Viral Load) is selected, list the test units	log
Was the client informed of HIV Status?	Indicate if the client was informed of their HIV status.	Yes
Was the client referred to HIV medical care?	Indicate if the client was referred to HIV medical care?	Yes
If yes, where was the client referred?	Indicate where the client was referred for HIV medical care.	DC Health and Wellness Clinic
If no, reason the client was not referred to HIV medical care?	Indicate the reason why the client was not referred to HIV	Patient already in care

	medical care from the drop down menu.	
CDC Required HIV Reporting		
Has the person previously used antiretroviral (ARV) medications?	Indicate if the client has previously used antiretroviral (ARV) medications. If yes, three new field will become available. This field will only become available if you are reporting a HIV-positive case.	Yes
Date ARV began	Enter the date that the client began their ARV use. You can enter the date manually or click on the "Calendar icon" to enter the date. If only month and year are available, please select the first day of the month. This field will only become available if you select "Yes" in the "Has the person previously used antiretroviral (ARV) medications" field.	12/04/2018 (MM/DD/YYYY)
Date of Last ARV use	Enter the date that the client last took their ARV. You can enter the date manually or click on the "Calendar icon" to enter the date. If only month and year are available, please select the first day of the month. This field will only become available if you select "Yes" in the "Has the person previously used antiretroviral (ARV) medications" field.	12/04/2018 (MM/DD/YYYY)
Specify antiretroviral medications	Select the client's antiretroviral (ARV) medication from the drop down menu. You will be able to enter up to five different types of ARVs. This field will only become available if you select "Yes" in the "Has the person previously used antiretroviral (ARV) medications" field.	Atripla

Syphilis		
With manifestation of:	**Late Clinical** May include inflammatory lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue. Rarely, other structures (e.g., the upper and lower respiratory tracts, mouth, eye, abdominal organs, reproductive organs, lymph nodes, and skeletal muscle) may be involved. In addition, certain neurologic manifestations (e.g., general paresis and tabes dorsalis) are also late clinical manifestations of syphilis. **Neurological** Infection of the central nervous system with T. pallidum, as evidenced by manifestations including syphilitic meningitis, meningovascular syphilis, general paresis, including dementia, and tabes dorsalis. **Ocular** Infection of any eye structure with T. pallidum, as evidenced by manifestations including posterior uveitis, panuveitis, anterior uveitis, optic neuropathy, and retinal vasculitis. Ocular syphilis may lead to decreased visual acuity including permanent blindness. **Otic** Infection of the cochleovestibular system with T. pallidum, as evidenced by manifestations including sensorineural hearing loss, tinnitus, and vertigo.	Ocular, Otic

Stage	**Primary (Chancre)** Characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance. **Secondary (Rash, etc.)** Characterized by localized or diffuse mucocutaneous lesions (e.g., rash such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy. Other signs can include mucous patches, condyloma lata, and alopecia. The primary ulcerative lesion may still be present. **Early Latent** Initial infection has occurred within the previous 12 months, but there are no signs or symptoms of primary or secondary syphilis. **Late Latent/Tertiary** Initial infection has occurred >12 months previously or in which there is insufficient evidence to conclude that infection was acquired during the previous 12 months. **Congenital** A condition caused by infection in utero with Treponema pallidum. A wide spectrum of severity exists, from unapparent infection to severe cases that are clinically apparent at birth. An infant or child (aged less than 2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome	Secondary (rash, etc.)

	and/or malnutrition). An older child may have stigmata (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints). **Stillbirth** A fetal death that occurs after a 20-week gestation or in which the fetus weighs greater than 500 g and the mother had untreated or inadequately treated syphilis at delivery.	
Was treatment provided?	Indicate the patient's treatment status using the drop down menu.	Yes
Syphilis Treatment Initiated	The name of the treatment regimen prescribed to the patient.	Bicillin 2.4mu IMx1
Other Treatment	The name of the treatment regimen prescribed to the patient, if not previously indicated	
Syphilis Date Treatment Initiated	The date the patient received medication/treatment services.	05/10/2018 (MM/DD/YYYY)
If referred for treatment, where?	The facility/provider the patient was referred to for treatment services	DC Health and Wellness Clinic
Date of most recent RPR	The date of the most recent Rapid Plasma Reagin test.	05/10/2018
RPR Result	The positive or negative result of the Rapid Plasma Reagin test.	Positive
Quantitative RPR 1:	The ratio results of the most recent quantitative Rapid Plasma Reagin Test (only the number following the 1:)	128
Describe symptoms if any:	The physical or mental feature that is appears apparent on the patient indicating a condition of syphilis.	Small chancre in rectum.
CSF-VDRL Date:	The date the test was conducted	05/10/2018 (MM/DD/YYYY)

CSF-VDRL Titer Results: 1:	The ratio results of the most recent CSF-VDRL (only the number following the 1:)	256
Tuberculosis		
Country of origin if not US	The country the client was born if not from the US. Leave blank if the client is from the US.	China, Pakistan, Nigeria, etc.
Date arrived in the US	The date the client arrived to the US. Leave blank if the client is from the US.	01/22/1990
Marital Status	Indicate the client's marital status.	Single, Married, Divorced, etc.
Occupation	Indicate the client's occupation.	Law Enforcement, Military, Healthcare, etc.
Classification	Indicate the client's TB classification.	Tuberculosis suspect
Signs and symptoms	Indicate the client's signs and symptoms. This field will become available for selecting any answer from "Classification."	Coughing up blood
Diagnosis Date	Enter the date the client was diagnosed with Tuberculosis.	05/10/2018 (MM/DD/YYYY)
Diagnosis site	Indicate the client's diagnosis. Check all that apply. If "Other" is a selected, a new field will become available.	Pulmonary
Other, Please specify	Indicate the client's other diagnosis. This field will only become available if "Other" was selected from the "Diagnosis" field.	
Immunocompromised?	Indicate if the client is immunocompromised	Yes
Type of specimen	Indicate the type of specimen for the Bacteriology Test 1. If "other" selected a new field will become available	Fluid
Other, please specify	Indicate the "other" kind of specimen collected for the TB test.	
Date of collection	Indicate the date the specimen was collected.	05/10/2018 (MM/DD/YYYY)

Bacteriology: Smear Result	Indicate the Smear result from the drop-down menu.	Positive
Bacteriology: Culture Result	Indicate the culture result from the drop-down menu.	Negative
Laboratory Performed	Indicate the laboratory that performed the bacteriology.	Lab Corps
NAAT Test Result	Indicate the NAAT Test Result.	Negative
NAAT Test Result Date	Indicate the date the NAAT Test results were completed.	05/10/2018 (MM/DD/YYYY)
GeneXpert Test Result	Indicate the GeneXpert Test result.	Positive
GeneXpert Test Result Date	Indicate the date the GeneXpert Test results were completed.	05/10/2018 (MM/DD/YYYY)
Chest X-Ray	Indicate the results of the client's chest x-ray. Select all that apply. If a chest x-ray was not done, please select "Not Done."	Abnormal
Date of X-Ray	Indicate the date of the Chest X-Ray. If "Not Done" was selected in the "Chest X-Ray" field, this field will not become available.	05/10/2018 (MM/DD/YYYY)
Tuberculin Skin Test	Indicate the type of skin test that was performed on the client. Check all that apply. If "Significant Size" is selected, a new field will become available. If "Other" is selected, a new field will become available.	T-Spot
Significant Size (mm)	Indicate the size of the client's Tuberculin Skin Test. This field will only become available if you selected "Significant Size" in the "Tuberculin Skin Test" field.	10mm
Other, Please specify	If other, indicate the client's other Tuberculin Skin Test. This field will only populate if you selected "Other" in the "Tuberculin Skin Test" field.	
Date Read	Indicate the date that the skin test was read. If "Not Done" was selected in "Tuberculin Skin	05/10/2018 (MM/DD/YYYY)

	Test" this field will not become available.	
Interferon Gamma Release Assay	Indicate the Gamma Release Assay results	Positive
Test Date	Indicate the Test date of the Interferon Gamma Release Assay	05/10/2018 (MM/DD/YYYY)
Chemotherapy Dosage	Indicate the client's prescribed chemotherapy dosage. Select all that apply. If you select other, a new field will become available.	Isoniazid
Other, please specify	Indicate the client's other chemotherapy dosage. This field will only become available if you selected "Other" in the "Chemotherapy Dosage" field.	
Date Started	Indicate the date the Chemotherapy dosage was started.	05/10/2018 (MM/DD/YYYY)
Previous Diagnosis	Indicate if the client has been diagnosed with tuberculosis before. If "yes," a new field will become available.	Yes
Date	Indicate the date client was preciously diagnosed with tuberculosis. This field will only become available if you selected "Yes" in the "Previous Diagnosis" field.	05/10/2018 (MM/DD/YYYY)
TB Hospitalization Information		
Chart Number	Indicate the client's chart number.	RN546
Admission Date	Indicate the date the client was admitted to the hospital for their Tuberculosis diagnosis.	12/01/2018 (MM/DD/YYYY)
Discharge Date	Indicate the date the client was discharged from the hospital.	12/04/2018 (MM/DD/YYYY)
TB Patient Followed By		
First Name	Indicate the first name of the person that will be following the client's Tuberculosis treatment.	John

Last Name	Indicate the last name of the person that will be following the client's Tuberculosis treatment	Doe
Street Address	Indicate the employer's street address for the person that will be following the client's Tuberculosis treatment.	1234 K Street NW
City	Indicate the employer's city for the person that will be following the client's Tuberculosis treatment.	Washington
State	Indicate the employer's state for the person that will be following the client's Tuberculosis treatment from the drop down menu.	District of Colombia
Phone	Enter the phone number for the person that will be following the client's Tuberculosis treatment.	202-555-8675
Section 11: Prevention Testing Only: Linkage Attempts for Positive Clients		
Did you attempt to link to care?	Indicate if you attempt to link the client to care.	Yes
Was a 30 minute linkage add-on provided?	Indicate if a 30 minute linkage add-on provided to the client.	Yes
Date of link attempt	Indicate that date that you attempted to link your client to a provider. You will be able to add up to 6 attempts (for a total of 7 attempts).	12/04/2018 (MM/DD/YYYY)
Type of Linkage	Indicate the type of linkage attempt.	Phone call
Section 12: PrEP Services		
Did you provide linkage or counseling services for PrEP?	Indicate if the client was linked counseling were provided for PrEP.	Yes
Did you link client to PrEP education, including assessment of need?	**Prevention Testing Only** Indicate if the client was linked to Prep education that included assessment of needs. This field will only populate if you indicated "Yes" on "Did you	Yes

	provide linkage or counseling services for PrEP."	
Did you link client to a PrEP clinical visit?	**Prevention Testing Only** Indicate if you linked your client to a PrEP clinical visit. This field will only populate if you indicated "Yes" on "Did you provide linkage or counseling services for PrEP."	Yes
Did client receive PrEP medication?	**Prevention Testing Only** Indicate if your client received PrEP. This field will only populate if you indicated "Yes" on "Did you link client to a PrEP clinical visit?"	Yes
Section 13: Prevention Testing Only: PrEP Adherence		
Did you provide individual medication adherence counseling session?	Indicate if you client was provided a medication adherence counseling session. This field will only populate if you indicated "Yes" on "Did client receive PrEP medication."	Yes
Date of medication adherence counseling session	Indicate the date your client received their adherence counseling session. This field will only populate if you indicated "Yes" on "Did you provide individual medication adherence counseling session."	12/04/2018 (MM/DD/YYYY)
Section 14: Prevention Testing Only: PrEP Counseling		
Did client receive group counseling?	Indicate if you provided you client with group counseling.	Yes
Date of group counseling session	Indicate the date of the adherence counseling session. Up to six group session dates can be entered.	12/04/2018 (MM/DD/YYYY)
Did you provide serodiscordant couple counseling sessions for PrEP?	Indicate if you provided you client with serodiscordant couple counseling. If yes, a new field will become available.	Yes

Date of couple counseling session	Indicate the date of the couple counseling session. Up to six couple session dates can be entered.	12/04/2018 (MM/DD/YYYY)
Section 15: nPEP Services		
Did you provide referral service for nPEP?	Indicate if your client has received referral services for nPEP.	Yes
Did you link client to nPEP education, including assessment of need?	**Prevention Testing Only** Indicate if your client was linked to nPEP education that included a needs assessment. **This field will only become available if you indicated "Yes" in the "Did you provide referral services for nPEP?" field.**	Yes
Did you link client to an nPEP clinical visit?	**Prevention Testing Only** Indicate if you linked your client to an nPEP clinical visit. **This field will only become available if you indicated "Yes" in the "Did you provide referral services for nPEP?" field.**	Yes
Did client receive nPEP medication?	**Prevention Testing Only** Indicate if your client received nPEP medication. **This field will only become available if you indicated "Yes" in the "Did you provide referral services for nPEP?" field.**	Yes
Section 16: Pregnancy Reporting		
Is the patient engaged in obstetrical care?	Indicate if the client is in obstetrical care from the drop down menu. This field will only become available if you indicated that the client is female AND pregnant in the "Patient Identifiers and Demographics" field.	Yes
Expected Due Date	Indicate the expected due date of the pregnant female. You can enter the date manually or click on the "Calendar icon" to enter	12/04/2018 (MM/DD/YYYY)

	the date. This field will only become available if you indicated that the client is female AND pregnant in the "Patient Identifiers and Demographics" field.	
Anticipated Delivery Hospital	Indicate the client's anticipated delivery hospital.	Washington Hospital Center
Has the patient been previously diagnosed with any other following:	Indicate if the client has been diagnosed with any of the following diseases. Check all that apply. If you select any of these options, a new field will become available below "Is the patient engaged in specialists care?"	Hepatitis B
Is the patient engaged in specialists care?	Indicate if the patient is in specialists care from the drop down menu.	Yes
Do you suspect problems with any of the following in your client (check all that apply)	Indicate if you suspect your client has any of these issues.	Mental health
Section 17: Prevention Testing Only: Session Activities		
Session Activities	Indicate any associated activities that are related to the HIV testing event. For example, harm reduction counseling, condom usage, etc.	Referral
If applicable, add another activity		
Section 18: Comments		
Comments	This section is reserved for any comments you would like to leave for HAHSTA Staff. Examples of comments include: more information detailing risk behavior staff should know about immediately, the reporting of additional preliminary positive tests,	Client is homeless.

	alternate addresses or information that requires immediate follow up.	