

HAHSTA

Testing and Case Report Form

TECHNICAL GUIDANCE



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.

Technical Guidance

Section 1: Testing and Case Report Form

The screenshot shows a web form titled "Testing and Case Report Form". It has a dark header bar with the title. Below the header, there are two main sections. The first section, "Date Form Completed", contains a date input field with "02-11-2019" entered, a "Today" button, and a "M-D-Y" label. Below the date field is a small text "MM-DD-YYYY". The second section, "Program", has a light green background. It contains a dropdown menu with a blue border. The dropdown is open, showing four options: "Prevention Testing Program", "School Based Screening Program (SBSP)", "Youth Screening Services Program (YSSP)", and "TB Case Report ONLY". Below the dropdown, there is a text field with "Not Applicable (N/A)". Below the "Program" section, there is a text instruction: "Please complete and submit this form to DC Health within 48 hours of information about reporting requirements, please visit:". Below this instruction is a URL: "https://www.dcregs.dc.gov/Common/DCMR/RuleDetail.aspx?RuleId=R0020670".

1) Date Form Completed

- Enter the date that the form was completed. The date will automatically default to the current date.

2) 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

Section 2: Health Provider Information

| HEALTH PROVIDER INFORMATION | |
|--|---|
| Agency Name | <div><div></div><div></div></div> |
| Reporting Facility Name <small>* must provide value</small> | <div><div>Bread for the City</div><div>Community Family Life Services</div><div>Family Medical Counseling Services</div><div>HBI-DC</div><div>HIPS</div><div>Howard University</div><div>La Clinica del Pueblo</div><div>Latin American Youth Center</div><div>Mary's Center</div><div>Sasha Bruce</div><div>United Medical Center</div><div>Unity Health Care</div><div>Us Helping Us</div><div>Whitman Walker</div></div> |
| Person Completing Form | <div><div></div></div> |
| Person Completing Form Email | <div><div></div></div> |
| Phone | <div><div></div></div> |
| Fax | <div><div></div></div> |
| Session Date | <div><div></div><div>31</div><div>Today</div><div>M-D-Y</div></div> |

1) PREVENTION TESTING ONLY: Agency Name

- From the drop down menu, select your agency name. If you are not in an agency, leave this section blank.

| HEALTH PROVIDER INFORMATION | |
|--|--|
| Agency Name | <div><div>La Clinica del Pueblo</div><div></div></div> |
| Site Name - LCDP | <div><div></div><div></div></div> |
| Reporting Facility Name <small>* must provide value</small> | <div><div>Consulate of Guatemala</div><div>Consulate of Honduras</div><div>Consulate of Mexico</div><div>La Clinica del Pueblo</div><div>Carlos Rosario Intl. School</div><div>Consulate of El Salvador</div><div>Volviendo a Vivir</div><div>Columbia Heights Metro</div></div> |
| Person Completing Form | <div><div></div></div> |
| Person Completing Form Email | <div><div></div></div> |
| Phone | <div><div></div></div> |
| Fax | <div><div></div></div> |

2) PREVENTION TESTING ONLY: Site Name


- If your agency has more than one site, another drop down menu will become available. Select the site from the drop down menu.

| HEALTH PROVIDER INFORMATION | |
|--|--|
| Agency Name | <input type="text"/> |
| Reporting Facility Name <small>* must provide value</small> | <input type="text"/> <ul style="list-style-type: none"> AHF Blair Underwood (Dr. Cox-Iyamu) Andromeda Transcultural Health Bread for the City Capital Medical Associates Capitol Hill Community Health Children's National Medical Center CIDMAR Clinic Community Connections Community Education Group Community Family Life Services Community of Hope Contemporary Family Services Conway Health and Resource Center Core Health and Wellness Center Damien Ministries DC Comprehensive Primary Care DC Health and Wellness Center DC Jail Dr. Ashesh D. Patel |
| Person Completing Form | |
| Person Completing Form Email | |
| Phone | |
| Fax | |
| Session Date | |
| Program Announcement | <input type="text"/> (select only one) |

3) Reporting Facility Name

- Enter the name of the facility, practice, or organization reporting the event to the health department.

HEALTH PROVIDER INFORMATION

| | |
|--|--|
| Agency Name | <input type="text"/> |
| Reporting Facility Name <small>* must provide value</small> | <input type="text" value="Other"/> |
| Other Reporting Facility Name <small>* must provide value</small> | <input type="text"/> |
| Person Completing Form | <input type="text"/> |
| Person Completing Form Email | <input type="text"/> |
| Phone | <input type="text"/> |
| Fax | <input type="text"/> |
| Session Date | <input type="text"/>  Today M-D-Y |
| Program Announcement | <input type="text"/> <small>(select only one)</small> |

4) Other Reporting Facility

- If “Other” is selected for Reporting Facility Name, the facility name must be entered in Other Reporting Facility Name.

5) Person Completing Form

- First and last name of the person who completed the form.
- This should be the designated person responsible for the information provided and may differ from the person who collected the information.

6) Person Completing Form Email

- Enter the email of the individual completing the form.

7) Phone

- Record the telephone number of the person completing the form.

8) Fax

- Record the fax number of the person completing the form.

9) PREVENTION TESTING ONLY: Session Date

- Enter the date the testing session took place.

| | |
|----------------------|---|
| Program Announcement | <div> <div></div> <div> PS15-1509 Local HCA External </div> </div> |
| Service Type | <div> <div></div> </div> |

10) PREVENTION TESTING ONLY: Program Announcement

- Indicate the program type that your organization or agency is participating in. If this section does not apply to you, please leave this section blank.

| | |
|----------------|---|
| Service Type | <div> <div></div> <div> Inpatient Outpatient ER Record Not Resulting in Admission Screening, Diagnosis, and Referral Agency Unknown </div> </div> |
| Street Address | <div> <div></div> </div> |
| State | <div> <div></div> </div> |

11) Service Type

- Select the type of service provided.
- If service type is unknown, select "Unknown."
- If service type is not available, leave the answer blank.

| | |
|----------------|--------------------------------|
| Street Address | <input type="text"/> |
| State | <input type="text" value="▼"/> |
| City | <input type="text"/> |
| County | <input type="text"/> |
| Country | <input type="text" value="▼"/> |
| Zip Code | <input type="text"/> |

12) Street Address

- Enter the facility's current street number and name

13) State

- Enter Facility's current state
- If the selected state is "District of Columbia" ward will become available.
- If the selected state is not "District of Columbia," county will remain available.

14) City

- Enter the facility's city.

15) County/Ward

- Enter the facility's county or ward.
 - If the facility is on the District of Columbia, please enter the ward.
 - If the facility is outside of the District of Columbia, please enter the county.

16) Country

- Select the facility's country from the drop down menu.

17) ZIP Code

- Enter the facility's ZIP code

Section 3: Client Identifiers and Demographics

| CLIENT IDENTIFIERS AND DEMOGRAPHICS | |
|---|--|
| Last Name <small>* must provide value</small> | <input type="text"/> |
| First Name <small>* must provide value</small> | <input type="text"/> |
| Middle Name | <input type="text"/> |
| Date of Birth <small>* must provide value</small> | <input type="text"/> <small>MM-DD-YYYY</small> <small>Today</small> <small>M-D-Y</small> |
| Social Security Number | <input type="text"/> |
| Client ID | <input type="text"/> |
| Medical Record Number | <input type="text"/> |

- 1) Last Name
 - Enter the last name of the client.
- 2) First Name
 - Enter the first name of the client.
- 3) Date of Birth
 - Enter the date of birth of the client.
- 4) Social Security Number
 - Enter the 9-digit social security number for the client.
 - If all nine are not known, enter the last four digits in the last space.
 - If the client does not have a social security number, please leave the field blank.
- 5) PREVENTION TESTING ONLY: Client ID
 - Indicate the client's ID if applicable. Ex. JOSM1234
- 6) Medical Record Number
 - Enter the medical record number used to identify the client at the reporting facility.
 - If the client does not have a medical record number, please leave the field blank.

| | |
|---|---|
| Sex assigned at birth | <input type="text"/> |
| Current Gender Identity: | <input type="text"/> <ul style="list-style-type: none"> Female Male Declined to Answer |
| Ethnicity <small>* must provide value</small> | <input type="text"/> |
| Race <small>* must provide value</small> | <input type="text"/> |

7) Sex assigned at birth

- Enter the sex assigned at birth for the client.
- This may differ from the gender identity of the client.

| | |
|---|--|
| Sex assigned at birth | <input type="text"/> |
| Current Gender Identity: | <input type="text"/> <ul style="list-style-type: none"> Female Male Transgender Male Transgender Female Transgender Unspecified Additional Gender Identity Declined |
| Ethnicity <small>* must provide value</small> | <input type="text"/> |
| Race <small>* must provide value</small> | <input type="text"/> |

8) Current Gender Identity

- Enter the current gender identified by the client

| | |
|---|---|
| Current Gender Identity: | <input type="text"/> |
| Ethnicity <small>* must provide value</small> | <input type="text"/> <ul style="list-style-type: none"> Hispanic or Latino NOT Hispanic or Latino Declined to Answer Don't Know |
| Race <small>* must provide value</small> | <input type="text"/> |

9) Ethnicity

- Enter the client's reported ethnicity.
- If no ethnicity information is available, select "Unknown".

* must provide value

Race

* must provide value

Additional Race

American Indian / Alaska Native

Asian

Black / African American

Native Hawaiian / Other Pacific Islander

White

Unknown

10) Race

- Enter the applicable selection as reported by the client.
 - This question should be answered even if information was entered for ethnicity.
 - If no race information is available, select “Unknown.”

11) Additional Race

- In the event the client identifies as more than one race, please indicate the client’s additional race here.

Additional Race

If female, pregnant?

Yes

No

Declined to Answer

Don't Know

Yes

12) If female, pregnant?

- Indicate the pregnancy status if your client’s sex assigned at birth is female. **This field will only become available if the client indicates that they are “female” for “Sex assigned at birth.”**

If female, pregnant?

If pregnant, in care?

No

Yes

Not Asked

Declined to Answer

Don't Know

13) 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.**

Section 4: Client Contact Information

| CLIENT CONTACT INFORMATION | |
|----------------------------|--|
| Address Type | <div><div></div><div>Residential</div><div>Correctional Facility</div><div>Foster Home</div><div>Homeless</div><div>Postal</div><div>Shelter</div><div>Temporary</div><div>Bad/Invalid Address</div></div> |
| Current Street Address | <input type="text"/> |
| Apartment Number | <input type="text"/> |

1) Address Type

- Indicate the client's current residential address.
 - Residential**- Client is currently residing at the address listed.
 - Correctional Facility**- Client is currently residing within a correctional facility.
 - Foster Home**- Client is residing in a foster home.
 - Homeless**- Client does not have a physical address in which they reside but you have an address that most accurately describes where they stay.
 - Postal**- Postal box address.
 - Shelter**- Client is currently residing in a shelter home.
 - Temporary**- The address given is not a permanent address (e.g., client living with friend, away at college, or with a family member).
 - Bad/Invalid Address**- The address provided by the client does not exist. If you are able to, the DC master Address Repository can be searched for valid District of Columbia addresses here:
<http://dcatlas.dcgis.dc.gov/mar/>.

| | |
|------------------------|----------------------|
| Current Street Address | <input type="text"/> |
| Apartment Number | <input type="text"/> |

2) Current Street Address

- Indicate the house number and street address of the client

3) Apartment Number

- Indicate the apartment number of the client. Leave the section blank if this does not apply to the client.

| | |
|------------------------|--|
| Apartment Number | <input type="text"/> |
| State | <div> <div></div> <div>Alaska</div> <div>Alabama</div> <div>Arkansas</div> <div>Arizona</div> <div>California</div> <div>Colorado</div> <div>Connecticut</div> <div>District of Columbia</div> <div>Delaware</div> <div>Foreign Country</div> <div>Florida</div> <div>Georgia</div> <div>Hawaii</div> <div>Iowa</div> <div>Idaho</div> <div>Illinois</div> <div>Indiana</div> <div>Kansas</div> <div>Kentucky</div> <div>Home</div> <div>Mobile</div> </div> |
| City | <input type="text"/> |
| County | <input type="text"/> |
| Zip Code | <input type="text"/> |
| Home Phone Number | <input type="text"/> |
| Mobile Phone Number | <input type="text"/> |
| Preferred Phone Number | <input type="text"/> |

[reset](#)

4) State

- Indicate the client's state of residency from the drop down list.

5) City

- Indicate the city that the client resides in. If unknown, please leave this field blank.

6) County/Ward

- Enter the client's residential county or ward.
 - If the client resides in the District of Columbia, please enter the ward.
 - If the client resides outside of the District of Columbia, please enter the county.

7) Zip Code

- Indicate the Zip Code of the client. If unknown, please leave this field blank

| | |
|------------------------|--|
| Home Phone Number | <input type="text"/> |
| Mobile Phone Number | <input type="text"/> |
| Preferred Phone Number | <input type="radio"/> Home <input type="radio"/> Mobile reset |
| Email Address | <input type="text"/> |

- 8) Home Phone Number
 - Indicate the home phone number of the client. If unknown, please leave blank
- 9) Mobile Phone Number
 - Indicate the mobile phone number of the client. If unknown, please leave blank
- 10) Preferred Phone Number
 - Indicate the preferred contact phone number of the client
- 11) Email Address
 - Indicate the email address of the client. If unknown, please leave this field blank

Section 5: Emergency Contact Person

| EMERGENCY CONTACT PERSON | |
|--------------------------------|----------------------|
| Emergency Contact Name | <input type="text"/> |
| Emergency Contact Phone | <input type="text"/> |
| Emergency Contact Relationship | <input type="text"/> |

- 1) Emergency Contact Name
 - Indicate the name of the client's emergency contact.
- 2) Emergency Contact Phone
 - Indicate the phone number for the client's emergency contact.
- 3) Emergency Contact Relationship
 - Indicate the relationship for the client's emergency contact
 - E.g., Spouse, Partner, Mother, Father, Brother, Sister, Friend, etc.

Section 6: Risk History

| RISK HISTORY | |
|---|---|
| For clients completing a risk profile, did the client report the following behaviors in the past 12 months? (select all that apply) | |
| Did Client Complete a Behavior Risk Profile? | <input type="radio"/> Yes <input type="radio"/> No |
| reset | |

1) PREVENTION TESTING ONLY: Did client complete a Behavior Risk Profile?

- Indicate if the client completed a Behavior Risk Profile.

| | |
|---|----------------------------------|
| Sex with a male | <input type="text" value="Yes"/> |
| Who is an injection drug user (IDU) | <input type="text"/> |
| Who is Human Immunodeficiency Virus (HIV) positive | <input type="text"/> |
| Who has received any of the following | |
| <input type="checkbox"/> Transplant <input type="checkbox"/> Transfusion <input type="checkbox"/> Hemophilia/Coagulation Disorder | |

2) Sex with a male

- Indicate if the client had sex with a male. If yes is selected, three new fields will become available.

3) Who is an injection drug user (IDU)

- Indicate if the client had sex with a male and is an injection drug user (IDU)

4) Who is Human Immunodeficiency Virus (HIV) positive

- Indicate if the client had sex with a male and who is HIV positive

5) 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.

| | |
|---|----------------------------------|
| Sex with a female | <input type="text" value="Yes"/> |
| Who is an injection drug user (IDU) | <input type="text"/> |
| Who is Human Immunodeficiency Virus (HIV) positive | <input type="text"/> |
| Who has received any of the following <input type="checkbox"/> Transplant <input type="checkbox"/> Transfusion <input type="checkbox"/> Hemophilia/Coagulation Disorder | |

- 6) Sex with female
 - Indicate if the client had sex with a female. If yes, three new fields will become available.
- 7) Who is an injection drug user (IDU)
 - Indicate if the client had sex with a female and is an injection drug user (IDU)
- 8) Who is Human Immunodeficiency Virus (HIV) positive
 - Indicate if the client had sex with a female and who is HIV positive
- 9) 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.

| | |
|---|----------------------------------|
| Sex with a person who is transgender | <input type="text" value="Yes"/> |
| Who is an injection drug user (IDU) | <input type="text"/> |
| Who is Human Immunodeficiency Virus (HIV) positive | <input type="text"/> |
| Who has received any of the following <input type="checkbox"/> Transplant <input type="checkbox"/> Transfusion <input type="checkbox"/> Hemophilia/Coagulation Disorder | |

10) Sex with a person who is transgender

- Indicate if the client had sex with a person who is transgender.

11) Who is an injection drug user (IDU)

- Indicate if the client had sex with a transgender and is an injection drug user (IDU)

12) Who is Human Immunodeficiency Virus (HIV) positive

- Indicate if the client had sex with a transgender and who is HIV positive

13) 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.

| | |
|--|---|
| Used injected non-prescription drugs? | <input type="text" value="Yes"/> |
| Share drug injection equipment | <input type="text"/> |
| Worked in a healthcare or clinical laboratory setting | <input type="text" value="Yes"/> <input type="text" value="No"/> <input type="text" value="Unknown"/> |

14) Used injected non-prescription drugs?

- Indicate if the client used injected non-prescription drugs. If, yes a new field will become available.

15) Share drug injection equipment

- Indicate if the client shared drug injection equipment.

| | |
|---|----------------------|
| Worked in a healthcare or clinical laboratory setting | ▼ |
| Was the patient perinatally exposed (<18 months old) to the disease being reported? | Yes No Unknown |

16) Worked in a healthcare or clinical laboratory setting

- Indicate if the client worked in a healthcare or clinical laboratory setting.
- If no, proceed to the next field.
- If yes, two new fields will become available.

| | | |
|---|--|-------|
| Sex with a male | Physician Surgeon/OBGYN Dentist Nurse Health aide Paramedic (EMT) Technician, Clinical Lab Technician, Dialysis Technician, Surgical Embalmer Technician, Other Respiratory Therapist Acupuncturist Therapist, Other Pharmacist Dietician Maintenance Worker Social Service Worker Administrative Worker | reset |
| Sex with a female | | |
| Sex with a person who is transgender | | |
| Used injected non-prescription drugs? | | |
| Worked in a healthcare or clinical laboratory setting | | |
| Yes, specify occupation and setting: | | ▼ |

17) 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.

| | |
|---|-------|
| Worked in a healthcare or clinical laboratory setting | Yes ▼ |
| Yes, specify occupation and setting: | ▼ |
| Setting | |

18) Setting

- Indicate the type of setting if "Other" was selected in "Yes, specify occupation and setting."

| | |
|---|--|
| Worked in a healthcare or clinical laboratory setting | <input type="text" value="No"/> |
| Was the patient perinatally exposed (<18 months old) to the disease being reported? | <input type="text" value=""/> |
| Was the client linked to social and behavioral support services? | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> No |

[reset](#)

- 19) Was the client perinatal exposed (<18 months old) to the disease being tested?
- Indicate if the client was perinatal exposed to the disease(s) being tested.

| | |
|---|---|
| Worked in a healthcare or clinical laboratory setting | <input type="text" value="No"/> |
| Was the patient perinatally exposed (<18 months old) to the disease being reported? | <input type="text" value=""/> |
| Was the client linked to social and behavioral support services? | <input type="radio"/> Yes <input type="radio"/> No |

[reset](#)

- 20) PREVENTION TESTING ONLY: Was the client linked to social and behavioral support services?
- Indicate if the client was linked to social behavioral support services.

Section 7: Client History

| CLIENT HISTORY | |
|-------------------------|--|
| Date of exam/test: | <input type="text" value=""/> <small>MM-DD-YYYY</small> |
| Reason for exam/testing | <input type="text" value=""/> |

- Date of exam/test
 - Indicate the date of the exam/test.
- Reason for exam/testing
 - Indicate the reason the client was examined/ tested

| | |
|--------------------|--|
| Previous HIV Test? | <input type="text"/> <ul style="list-style-type: none"> No Yes Don't Know |
|--------------------|--|

3) Previous HIV Test?

- Indicate if the client had a previous HIV test.
- If no, proceed to the next field “Was client referred to STI testing?”
- If yes, a new field will become available.

| | | |
|---------------------------------------|---|-------|
| Previous HIV Test? | Yes | |
| If yes, what is the client's result? | <input type="text"/> <ul style="list-style-type: none"> Recorded Confirmed Positive Recorded Confirmed Negative Record Confirmed Preliminary Positive Record Confirmed indeterminate Self Reported Negative Self Reported Positive No Confirmed Record, No Self Report | |
| Was client referred to STI testing? | | reset |
| Was client referred to HIV screening? | <input type="radio"/> Yes | |

4) If yes, what is the client's result?

- Indicate the client's result from the drop down menu. **This field will only become available if you indicate “yes” on “Previous HIV test.”**

| | | |
|---------------------------------------|---|-------|
| Was client referred to STI testing? | <input type="radio"/> Yes <input type="radio"/> No | reset |
| Was client referred to HIV screening? | <input type="radio"/> Yes <input type="radio"/> No | reset |

5) PREVENTION TESTING ONLY: Was client referred to STI testing?

- Indicate if the client was referred to STI testing.

6) PREVENTION TESTING ONLY: Was client referred to HIV screening?

- Indicate if the client was referred to HIV screening.

Section 8: Prevention Testing Only: Testing Event Reporting

THIS SECTION IS REQUIRED FOR ALL PREVENTION TESTING EVENTS.

| TESTING EVENT REPORTING | |
|-------------------------|---|
| Prevention Test 1 | |
| Test Type | <div><div>Chlamydia</div><div>Gonorrhea</div><div>Hepatitis B</div><div>Hepatitis C</div><div>HIV</div><div>Syphilis</div><div>Tuberculosis</div><div>Other</div></div> |
| Sample Date | <div><div>Today</div><div>M-D-Y</div></div> |
| Worker ID | <div></div> |

- 1) Test Type
 - Indicate the test type from the drop down menu
- 2) If “Other” Please Specify
 - Please specify what type of test was conducted.

| | |
|-----------------|---|
| Sample Date | <div><div></div><div>Today</div><div>M-D-Y</div></div> |
| Worker ID | <div></div> |
| Test Election | <div><div></div><div>Anonymously</div><div>Confidentially</div><div>Test Not Offered</div><div>Declined Testing</div></div> |
| Test Technology | <div></div> |

- 3) Sample Date
 - Indicate the date the sample was acquired.
- 4) Worker ID
 - Indicate worker ID that the facility has assigned to the individual who is performing the tests. This information could be the name or an identification code for the individual performing the test. Ex. Od5, John Smith, SmithJ, etc.
- 5) Test Election
 - Indicate the test election from the drop down menu.

| | |
|-----------------|--|
| Test Technology | <div> <div></div> <div> Conventional Rapid NAAT/RNA Testing Other </div> </div> |
| Test Result | |
| Result Provided | <div> <div></div> <div></div> </div> |

6) Test Technology

- Indicate the test technology from the drop down menu. **This field is only for HIV Testing.**

| | |
|-----------------------|-------|
| Test Technology | Other |
| Other, please specify | |
| Test Result | |

7) Other, please specify

- Indicate the “other” test technology in this field. **This field will only become available if you indicated “Other” in the “Test Technology” field.**

| | |
|-------------|--|
| Test Result | <div> <div></div> <div> Positive/Reactive Negative Indeterminate Invalid No Result </div> </div> |
|-------------|--|

8) Test Result

- Indicate the client’s test result.

| | |
|-----------------|---|
| Test Result | Positive/Reactive |
| Result Provided | <div> <div>No</div> <div> No Yes Yes, client obtained results from another agency </div> </div> |

9) Results provided

- Indicate if the client was informed of their test results.
- If you select “No,” a new field will become available.

| | |
|-------------------------------|--|
| Result Provided | No |
| If Results NOT provided, why? | Other |
| | Declined Notification Did Not Return/ Could Not Locate Other |

10) If Results NOT provided, why?

- Indicate the reason why the client was not informed of their test results.
- If you select “Other,” a new field will become available.

| | |
|------------------------------------|-------|
| Result Provided | No |
| If Results NOT provided, why? | Other |
| Result Not Provided Other, specify | |

11) Results Not Provided Other, specify

- Indicate the “other” reason for why the client was not provided their test result.

Section 9: PrEP Knowledge and Utilization

| PrEP Knowledge and Utilization | |
|---|---|
| Has Client ever heard of Pre-Exposure Prophylaxis (PrEP)? | |
| Is the client currently taking daily PrEP medication? | Yes, confirmed No Don't Know |
| Has the client used PrEP anytime in the last 12 months? | <input type="radio"/> Yes <input type="radio"/> No |

1) Has client ever heard of Pre-Exposure Prophylaxis (PrEP)?

- Indicate if the client has ever heard of Pre-Exposure Prophylaxis (PrEP).

2) Is the client currently taking daily PrEP medication?

- Indicate if the client is currently taking PrEP medication.

3) Has the client used PrEP anytime in the last 12 months?

- Indicate if the client has used PrEP anytime in the last 12 months.

Section 10: Disease Reporting

| DISEASE REPORTING | |
|--|---|
| Reporting Diseases | |
| <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> TB | |
| Was the patient notified that they may be contacted by DOH Disease Intervention Specialist (DIS) | <div><div></div><div>Yes</div><div>No</div></div> |
| Linkage Attempts for Positive Clients | |

- 1) Reporting Diseases
 - Indicate the disease that you are reporting.
- 2) Was the client notified that they may be contacted by DOH Disease Intervention Specialists (DIS)?
 - Indicate if the client was notified that they may be contacted by DOH Disease Intervention Specialists from the drop down menu.

Chlamydia

| Chlamydia | |
|--|----------------------|
| Positive specimen site (check all that apply) | |
| <input type="checkbox"/> Genital <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input checked="" type="checkbox"/> Other | |
| Other positive specimen site | <input type="text"/> |

- 1) Positive specimen site (check all that apply)
 - Indicate the specimen site
 - If “Other” is selected, a new field will become available.
- 2) Other positive specimen site
 - Indicate the other specimen site. **This field will only become available if you selected “Other” in “Positive specimen site.”**

| Chlamydia | |
|--|---|
| Positive specimen site (check all that apply) | |
| <input type="checkbox"/> Genital <input type="checkbox"/> Urine <input checked="" type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Other | |
| Was treatment provided? <small>* must provide value</small> | <div><div>Yes</div><div>Referred Elsewhere</div><div>Declined Treatment</div><div>Lost to Follow-up</div></div> |

3) Was treatment provided?

- Use the drop down to indicate the treatment status.
- If the client was treated for chlamydia, please select yes
- If the client was referred to another provider/clinic for treatment, please select referred elsewhere.

| | |
|--|---|
| Was treatment provided? <small>* must provide value</small> | Yes  |
| Treatment <small>* must provide value</small> | |
| <input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> Azithromycin 2g <input type="checkbox"/> Doxycycline 100mg BID x 7 days <input checked="" type="checkbox"/> Other | |
| Other Treatment <small>* must provide value</small> | |
| <input type="text"/> | |
| Date Treated <small>* must provide value</small> | <input type="text"/>  Today M-D-Y <small>MM-DD-YYYY</small> |

4) Treatment


- Indicate the treatment the patient was given.
- If the client was given a treatment other than the options listed, please select “other”

5) Other Treatment

- Indicate the “Other Treatment” in this field. This field will only become available if you selected “Other” in “Treatment.”

6) Date Treated

- Indicate the date the “Other Treatment” was administered.

| | |
|---|--|
| Was treatment provided? <small>* must provide value</small> | Referred Elsewhere  |
| If referred for treatment, where? <small>* must provide value</small> | <input type="text"/> |

7) If referred for treatment, where?

- Indicate where the client was referred to treatment.


| | |
|---|----------------------|
| Was the client offered Chlamydia-expedited partner therapy (EPT)? | Yes ▼ |
| If yes, number of prescriptions/medications provided | <input type="text"/> |

- 8) Was the Client offered Chlamydia-expedited partner therapy (EPT)?
 - Indicate if the client was offered expedited partner therapy from the drop down menu.
- 9) If yes, number of prescriptions/medications provided
 - Indicate the number of prescriptions/medications provided for EPT. **This field will only become available if you selected “Yes” in the “Was the client offered Chlamydia-expedited partner therapy (EPT)” field.**

Gonorrhea

| Gonorrhea | |
|--|----------------------|
| Positive specimen site (check all that apply) | |
| <input type="checkbox"/> Genital <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input checked="" type="checkbox"/> Other | |
| Other positive specimen site | <input type="text"/> |

- 1) Positive specimen site (check all that apply)
 - Indicate the specimen site
 - If “Other” is selected, a new field will become available.
- 2) Other positive specimen site
 - Indicate the other specimen site. **This field will only become available if you selected “Other” in “Positive specimen site.”**

| | |
|---|--|
| Was treatment provided? <i>* must provide value</i> | <div>Yes</div> <div>Referred Elsewhere</div> <div>Declined Treatment</div> <div>Lost to Follow-up</div> |
| Treatment <i>* must provide value</i> | |
| <input type="checkbox"/> Ceftriaxone 250mg IM <input type="checkbox"/> Azithromycin 2g <input type="checkbox"/> Cefixime 400mg PO <input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> Doxycycline 100mg BID x 7 days <input type="checkbox"/> Gentamicin 240mg IM <input type="checkbox"/> Gemifloxacin 320mg PO <input checked="" type="checkbox"/> Other | |
| Other Treatment <i>* must provide value</i> | <input type="text"/> |
| Date Treated <i>* must provide value</i> | <input type="text"/>  Today M-D-Y MM-DD-YYYY |

3) Was treatment provided?

- Use the drop down to indicate the treatment status.
- If the client was treated for gonorrhea, please select yes
- If the client was referred to another provider/clinic for treatment, please select referred elsewhere.

4) Treatment

- Indicate the treatment the client was given.
- When the treatment is selected, another field will become available.

5) Other Treatment

- Indicate the “Other Treatment” in this field. **This field will only become available if you selected “Other” in “Treatment.”**

6) Date Treated

- Indicate the date the client was treated.

| | |
|---|---|
| Was treatment provided? <small>* must provide value</small> | <input type="text" value="Referred Elsewhere"/> |
| If referred for treatment, where? <small>* must provide value</small> | <input type="text"/> |

7) If referred for treatment, where?

- Indicate where the client was referred to treatment. **This field will only become available if you selected “Referred Elsewhere” in “Treatment.”**

| | |
|--|---|
| Was the client offered Gonorrhea-expedited partner therapy (EPT)? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| If yes, number of prescriptions/medications provided | <input type="text"/> |

8) Was the Client offered Gonorrhea-expedited partner therapy (EPT)?

- Indicate if the client was offered expedited partner therapy from the drop down menu.

9) If yes, number of prescriptions/medications provided

- Indicate the number of prescriptions/medication provided.

Hepatitis B

| Hepatitis B | |
|--|---|
| Diagnosis type <small>* must provide value</small> | <input type="button" value="Past"/> <input type="button" value="Current"/> |
| Date Diagnosed <small>* must provide value</small> | <input type="text"/> <input type="button" value="Today"/> <input type="button" value="MM-DD-YYYY"/> |
| Vaccinated? | <input type="button" value="V"/> <input type="button" value="N"/> |
| Describe symptoms if any: | <input type="text"/> |

1) Diagnosis Type

- Indicate if the client’s diagnosis is indicative of a past or current infection.

2) Date Diagnosed

- Indicate the date the client was diagnosed.

3) Vaccinated?

- Indicate if the client has been vaccinated for Hepatitis B.

4) Describe symptoms if any

- Indicate if there any symptoms for the client's Hepatitis B.

| | |
|--|---|
| Positive HBV-related Test: | <div>HBsAg HBsAb HBcAb Total HBcAb IgM</div> |
| Test sample date <small>* must provide value</small> | <input type="text"/> <small>Today</small> <small>M-D-Y</small> <small>MM-DD-YYYY</small> |
| Additional Positive HBV-related Test: | <input type="text"/> |

5) Positive HBV-related Test

- If positive, indicate the test type.

6) Test sample date

- Indicate the positive HBV-related test sample date

7) Additional Positive HBV-related Test

- Indicate the test type. This field will become available. Only fill this section out if you have another Hepatitis B test type for your client.

Hepatitis C

| | |
|--|---|
| Hepatitis C | |
| Diagnosis type <small>* must provide value</small> | <div>Past Current</div> |
| Date Diagnosed <small>* must provide value</small> | <input type="text"/> <small>Today</small> <small>M-D-Y</small> <small>MM-DD-YYYY</small> |
| Describe symptoms if any: | <input type="text"/> |
| Positive HCV-related Test: | <input type="text"/> |

1) Diagnosis Type


- Indicate if the client's Hepatitis C is past or current infection.

2) Date Diagnosed

- Indicate the date the client was diagnosed.

3) Describe symptoms if any

- Indicate if there any symptoms for the client's Hepatitis C.

| | |
|---|--|
| Positive HCV-related Test: | <div>Antibody HCV Screening Test Antibody HCV RIBA Antibody HCV RNA</div> |
| Test sample date <small>* must provide value</small> | <input type="text"/>  Today M-D-Y MM-DD-YYYY |
| Additional Positive HCV-related Test: | <input type="text"/> |

4) Positive HCV-related Test

- If positive, indicate the test type.



5) Test sample date

- Indicate the test sample date. **This field will only appear if you indicate the client's Hepatitis C test type.**

6) Additional Positive HCV-related Test

- Indicate the test type. **Only fill this section out if you have another Hepatitis C test type for your client.**

HIV

| | |
|---|--|
| HIV | |
| Was the diagnosis documented by a physician | <input type="text"/> |
| Date Diagnosed <small>* must provide value</small> | <input type="text"/>  Today M-D-Y MM-DD-YYYY |
| Positive HIV-related Test: <small>* must provide value</small> | HIV-1 IA (EIA or Other) <input type="text"/> |
| Test sample date <small>* must provide value</small> | <input type="text"/>  Today M-D-Y MM-DD-YYYY |

1) Was the diagnosis documented by a physician

- Indicate if the diagnosis was documented by a physician.

2) Date Diagnosed

- Indicate the date the client was diagnosed.

3) Positive HIV-related Test

- If the test is positive, indicate the test type from the drop down menu.


- 4) Test sample date
- Indicate the test sample date.

HIV-1/2 Type-Differentiating Immunoassay

| | |
|---|--|
| Positive HIV-related Test: <small>* must provide value</small> | HIV-1/2 Type-Differentiating Immunoassay ▼ |
| HIV Type Differentiating Result <small>* must provide value</small> | <div>HIV-1 HIV-2</div> |
| Test sample date <small>* must provide value</small> | <div><input type="text"/>  Today M-D-Y MM-DD-YYYY</div> |

- 5) HIV Type Differentiating Result
- Indicate the HIV Type Differentiating Result from the drop down menu.

HIV-1 RNA/DNA NAAT (Quantitative Viral Load)

| | |
|--|--|
| Positive HIV-related Test: <small>* must provide value</small> | HIV-1 RNA/DNA NAAT (Quantitative Viral Load) ▼ |
| Viral Load Result <small>* must provide value</small> | <input type="text"/> |
| Viral Load Test Units <small>* must provide value</small> | <div>Log Copies/mL</div> |
| Test sample date <small>* must provide value</small> | <div><input type="text"/>  Today M-D-Y MM-DD-YYYY</div> |

- 6) Viral Load Result
- Indicate the viral load test results.
- 7) Viral Load Test Units
- Indicate the test units from the drop down menu.

| | |
|--|--|
| Was the client informed of HIV status? <small>* must provide value</small> | <div><input type="text"/> ▼ Yes No Unknown</div> |
|--|--|

- 8) Was the client informed of HIV status?
- Indicate if the client was informed of their HIV status.

Was the client referred to HIV medical care?
* must provide value

Yes ▼

Yes
No
Unknown

9) Was the client referred to HIV medical care?

- Indicate if the client was referred to HIV medical care.
- If yes, one field will become available.
- If no, one field will become available.

Was the client referred to HIV medical care?
* must provide value

Yes ▼

If yes, where was the client referred
* must provide value

10) If yes, where was the client referred

- Indicate where the client was referred to HIV medical care. **This field will only become available if you selected “yes” in the “was the client referred to HIV medical care.”**

Was the client referred to HIV medical care?
* must provide value

No ▼

Reason the client not referred to HIV medical care?
* must provide value

Patient Declined Care ▼


11) If no, reason the client was not referred to HIV medical care?

- Indicate the reason why the client was not referred to HIV medical care from the drop down menu. **This field will only become available if you selected “no” in the “was the client referred to HIV medical care.”**

CDC Requires the following information on all preliminary and confirmed HIV-Positive Clients


CDC requires the following information on all preliminary and confirmed HIV-positive clients:

Has the person previously used antiretroviral (ARV) medications? Yes ▾

Date ARV began 11-01-2018  Today M-D-Y

Date of Last ARV Use

Specify antiretroviral medications



- 1) 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.**
- 2) 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.**
- 3) 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.**

| | |
|---|--|
| Specify antiretroviral medications | Atripla (efavirenz/emtricitabine/tenofovir DF) ▼ |
| If applicable, please specify additional medications: | Fortovase (saquinavir, SQV) ▼ |
| If applicable, please specify additional medications: | Fortovase (saquinavir, SQV) ▼ |
| If applicable, please specify additional medications: | Isentress (raltegravir) ▼ |

4) 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.**

Syphilis

| Syphilis | |
|---|---|
| With manifestation of: <input type="checkbox"/> Late Clinical <input type="checkbox"/> Neurological <input type="checkbox"/> Ocular <input type="checkbox"/> Otic | |
| Stage | <div> Primary (chancere) Secondary (rash, etc) Early Latent Late Latent/ Tertiary Congential Stillbirth </div> |
| Was treatment provided? <small>* must provide value</small> | |

1) With manifestation of (Select all that apply)

- Indicate the client's syphilis manifestation.

2) Stage

- Indicate the client's syphilis stage from the drop down menu.

| | |
|---|--|
| Was treatment provided? <small>* must provide value</small> | <div>Yes</div> <div>Referred Elsewhere</div> <div>Declined Treatment</div> <div>Lost to Follow-up</div> |
| Syphilis Treatment Initiated <small>* must provide value</small> | |
| <input type="checkbox"/> Bicillin 2.4mu IM x1 <input type="checkbox"/> Bicillin 2.4mu IM x3 weeks <input type="checkbox"/> Doxycycline 100mg po BID x 14 days <input type="checkbox"/> Doxycycline 100mg po BID x 28 days <input checked="" type="checkbox"/> Other Treatment | |
| Other Treatment <small>* must provide value</small> | <input type="text"/> |
| Syphilis Date Treatment Initiated <small>* must provide value</small> | <div> <input type="text"/> <div> <div>31</div> <div>Today</div> <div>M-D-Y</div> </div> </div> <div>MM-DD-YYYY</div> |

3) Was treatment provided?

- Use the drop down to indicate the treatment status.
- If the client was treated for syphilis, please select yes
- If the client was referred to another provider/clinic for treatment, please select referred elsewhere.

4) Syphilis Treatment Initiated

- Indicate the treatment initiated for your client.

5) Other Treatment

- If “Other Treatment” is selected, indicated the other treatment in this field.



6) Syphilis Date Treatment Initiated

- Indicate the date the syphilis treatment was initiated.

| | |
|---|-------------------------------|
| Was treatment provided? <small>* must provide value</small> | <div>Referred Elsewhere</div> |
| If referred for treatment, where? <small>* must provide value</small> | <input type="text"/> |

7) If referred for treatment, where?

- Indicate where the client was referred to for treatment.

| | |
|-----------------------------------|--|
| Date of most recent RPR | <input type="text"/> <div>  Today M-D-Y </div> MM-DD-YYYY |
| RPR Result | <div> Positive Negative Unknown </div> <input type="text"/> |
| Quantitative RPR 1: | <input type="text"/> |
| CSF-VDRL Date: | <input type="text"/> <div>  Today M-D-Y </div> MM-DD-YYYY |
| CSF-VDRL Titer Results: 1: | <input type="text"/> |
| Describe symptoms if any: | <input type="text"/> |

- 8) Date of most recent RPR
 - Indicate the date of the most recent RPR.
- 9) RPR Result
 - Indicate the client's RPR result from the drop down menu.
- 10) Quantitative RPR 1:
 - Indicate the client's quantitative RPR. Only input the dilution portion of the ratio. For example, if your client has a 1:32, only input the 32 in the field.
- 11) Describe symptoms if any
 - Describe any of your client's syphilis symptoms
- 12) CSF-VDRL Date
 - Indicate the date for CSF-VDRL date. Only the second part of the ratio is required. This field is only available if neurological manifestations is selected.
- 13) CSF-VDRL Titer Results
 - Indicate the client's CSF-VDRL titer results. Only the second part of the ratio is required. This field is only available if neurological manifestations is selected.


Tuberculosis

| TB | |
|-----------------------------|---|
| Country of Origin if not US | <input type="text"/> |
| Marital Status | <div><div>▼</div><div>Single Married Divorced Separated Widowed</div></div> |
| Occupation | <input type="text"/> |
| Classification | <div><div>▼</div></div> |

- 1) Country of Origin if not US
 - a. Indicate the client's country of origin if the client was not born in the US. If the client was born in the US, leave this section blank.
- 2) Date arrived in the US
 - a. Indicate the date the client arrived in the US. If the client was born in the US, leave this section blank.
- 3) Marital Status
 - a. Indicate the client's marital status.
- 4) Occupation
 - a. Indicate the client's occupation.
- 5) Marital Status
 - Indicate the client's marital status from the drop down menu.

| Classification | |
|--------------------|---|
| Classification | <div><div>Tuberculosis current disease Tuberculosis no current disease Tuberculosis suspect Tuberculosis infection no disease</div></div> |
| Signs and Symptoms | <input type="text"/> |

- 6) Classification
 - Indicate the client's TB classification.
- 7) Signs and Symptoms
 - Indicate the client's signs and symptoms. **This field will become available for selecting any answer from "Classification."**

| Diagnosis | |
|-----------------------|---|
| Diagnosis Date | <input type="text"/>  <input type="button" value="Today"/> M-D-Y |
| Diagnosis Site | <div> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Non-Pulmonary <input type="checkbox"/> Miliary <input type="checkbox"/> Bones and Joints <input type="checkbox"/> Lymphatic <input type="checkbox"/> Genitourinary <input type="checkbox"/> Meningitis <input type="checkbox"/> Pleural <input type="checkbox"/> Peritoneal <input type="checkbox"/> Reported at time of death <input checked="" type="checkbox"/> Other </div> |
| Other, please specify | <input type="text"/> |
| Immunocompromised? | <input type="radio"/> Yes <input type="radio"/> No |
| reset | |

8) Diagnosis Date

- Enter the date the client was diagnosed with Tuberculosis.

9) Diagnosis Site


- Indicate the client's diagnosis. Check all that apply.
- If "Other" is a selected, a new field will become available.

10) Other, please specify

- Indicate the client's other diagnosis. **This field will only become available if "Other" was selected from the "Diagnosis" field.**

11) Immunocompromised?

- Indicate if the client is immunocompromised.

| Bacteriology Test 1 | |
|------------------------------|--|
| Type of Specimen | Other ▼ |
| Other, please specify: | <input type="text"/> |
| Date of Collection | <input type="text"/>  Today M-D-Y |
| Bacteriology: Smear Result | <input type="text"/> ▼ |
| Bacteriology: Culture Result | <input type="text"/> ▼ |
| Laboratory Performed | <input type="text"/> |
| Bacteriology Test 2 | |
| Type of Specimen | <input type="text"/> ▼ |

12) Type of Specimen

- Indicate the type of specimen for the Bacteriology Test 1.
- If “other” selected a new field will become available.

13) Other, please specify:

- Indicate the “other” kind of specimen collected for the TB test.

14) Date of Collection

- Indicate the date that the specimen was collect.

15) Bacteriology: Smear Result

- Indicate the Smear result from the drop-down menu.




16) Bacteriology: Culture Result

- Indicate the Bacteriology cultures results.

17) Laboratory Performed

- Indicate the laboratory that performed the Bacteriology.

A maximum of eight different bacteriology tests can be entered.

| NAAT Test | |
|---|---|
| NAAT Test Result | <input type="text"/> |
| NAAT Test Result Date | <input type="text"/>  <input type="button" value="Today"/> M-D-Y |
| GeneXpert Test | |
| GeneXpert Test Result | <input type="text"/> |
| GeneXpert Result Date | <input type="text"/>  <input type="button" value="Today"/> M-D-Y |
| Chest X-Ray | |
| Chest X-Ray <input type="checkbox"/> Not Done <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving | |
| Date of X-Ray | <input type="text"/>  <input type="button" value="Today"/> M-D-Y |

18) NAAT Test Result

- Indicate the NAAT test result.

19) NAAT Test Result Date

- Indicate the date the NAAT Test result was completed.

20) GeneXpert Test Result

- Indicate the GeneXpert Test result.

21) GeneXpert Result Date


- Indicate the date the GeneXpert Test result was completed.

22) 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."

23) 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.**

| Tuberculin Skin Test | |
|--|--|
| Tuberculin Skin Test <input type="checkbox"/> Not Done <input type="checkbox"/> QuantiFERON <input type="checkbox"/> T-spot <input type="checkbox"/> Mantoux <input type="checkbox"/> Tine <input checked="" type="checkbox"/> Significant Size <input type="checkbox"/> Not Significant <input checked="" type="checkbox"/> Other | |
| Other, please specify: | <input type="text"/> |
| Significant Size (mm) | <input type="text"/> |
| Date Read | <input type="text"/>  Today M-D-Y |

24) 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.

25) Significant Size (mm)

- Indicate the size of the client’s Tuberculin Skin Test. Ex. 8mm, 10mm, etc. **This field will only become available if you selected “Significant Size” in the “Tuberculin Skin Test” field.**

26) 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.**

27) Date Read

- Indicate the date that the skin test was read. **If “Not Done” was selected in “Tuberculin Skin Test” this field will not become available.**


| Interferon Gamma Release Assay | |
|---------------------------------------|---|
| Interferon Gamma Release Assay | |
| Test Date | <div> <div> Positive Negative Indeterminate Borderline </div> <div> Today M-D-Y </div> </div> |

28) Interferon Gamma Release Assay

- Indicate the Gamma Release Assay results

29) Test Date

- Indicate the Test date of the Interferon Gamma Release Assay

| Chemotherapy Dosage | |
|--|---|
| Chemotherapy Dosage <input type="checkbox"/> Isoniazid <input type="checkbox"/> Rifampin <input type="checkbox"/> Ethambutol <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Streptomycin <input checked="" type="checkbox"/> Other | |
| Other, please specify: | <input type="text"/> |
| Date Started | <input type="text"/>  Today M-D-Y |

30) Chemotherapy Dosage


- Indicate the client's prescribed chemotherapy dosage. Select all that apply.
- If you select other, a new field will become available.

31) 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.**

32) Date Started

- Indicate the date the Chemotherapy dosage was started.

| Previous TB Diagnoses | |
|-------------------------|---|
| Previous Diagnosis? | <input type="text" value="Yes"/> |
| Previous Diagnosis Date | <input type="text"/>  Today M-D-Y |

33) Previous diagnosis

- Indicate if the client has been diagnosed with tuberculosis before.
- If "yes," a new field will become available.

34) Date

- Indicate the date client was previously diagnosed with tuberculosis. **This field will only become available if you selected "Yes" in the "Previous Diagnosis" field.**

TB Hospitalization Information

| Hospitalization Information | |
|-----------------------------|--|
| Chart Number: | <input type="text"/> |
| <hr/> | |
| Admission Date | <input type="text"/>  Today M-D-Y |
| <hr/> | |
| Discharge Date | <input type="text"/>  Today M-D-Y |

- 1) Chart Number
 - Indicate the client's chart number.
- 2) Admission Date
 - Indicate the date the client was admitted to the hospital for their Tuberculosis diagnosis.
- 3) Discharge Date
 - Indicate the date the client was discharged from the hospital.

TB Client followed by

| Client to be followed by: | |
|---------------------------|--------------------------------|
| First Name | <input type="text"/> |
| Last Name | <input type="text"/> |
| Street Address | <input type="text"/> |
| City | <input type="text"/> |
| State | <input type="text" value="v"/> |
| Phone Number | <input type="text"/> |

1) First Name

- Indicate the first name of the person that will be following the client's Tuberculosis treatment.

2) Last Name

- Indicate the last name of the person that will be following the client's Tuberculosis treatment.

3) Street Address

- Indicate the employer's street address for the person that will be following the client's Tuberculosis treatment.

4) City

- Indicate the employer's city for the person that will be following the client's Tuberculosis treatment.

5) State

- Indicate the employer's state for the person that will be following the client's Tuberculosis treatment from the drop-down menu.

6) Phone Number

- Enter the phone number for the person that will be following the client's Tuberculosis treatment.

Section 11: Prevention Testing Only: Linkage Attempts for HIV-Positive Clients

THIS SECTION IS REQUIRED FOR ONLY PREVENTION TESTING EVENTS.

Linkage Attempts for Positive Clients

Did you attempt to link to care?

☒ Yes☐ No

reset

1) Did you attempt to link to care?

- Indicate if you attempt to link the client to care.
- If yes, two field will become available below “Was a 30 minute linkage add-on provided?”

Was a 30 minute linkage add-on provided?

☒ Yes☐ No

reset

2) Was a 30 minute linkage add-on provided?

- Indicate if a 30 minute linkage add-on was provided to the client.

Date of linkage attempt 1

23-01-2019

Today

D-M-Y

Type of Linkage Attempt

▼

Phone CallLetterFace-to-FaceHome VisitEmailOther

3) Date of linkage attempt 1

- 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).**

4) Type of linkage attempt

- Indicate the type of linkage attempt.

Section 12: PrEP Services

| PrEP Services | |
|---|---|
| Did you provide linkage or counseling services for PrEP | <input type="radio"/> Yes <input type="radio"/> No |
| reset | |

- 1) Did you provide linkage or counseling services for PrEP?
 - Indicate if you linked or counseling services for PrEP to your client.
 - If yes, a new field will become available.


| | | |
|--|---|-----------------------|
| Did you link client to PrEP education, including assessment of need? | <input type="radio"/> Yes <input type="radio"/> No | reset |
| Did you link client to a PrEP clinical visit? | <input type="radio"/> Yes <input type="radio"/> No | reset |

- 2) Prevention Testing Only: Did you link client to PrEP education, including assessment of need?
 - Indicate if you linked your client to PrEP education to include assessment of need?
- 3) Prevention Testing Only: Did you link client to a PrEP clinical visit?
 - Indicate if you linked your client to PrEP clinical visit.
 - If yes, a new field will become available.

| | | |
|-------------------------------------|---|-----------------------|
| Did client receive PrEP medication? | <input type="radio"/> Yes <input type="radio"/> No | reset |
|-------------------------------------|---|-----------------------|



- 4) Prevention Testing Only: Did client receive PrEP medication?
 - Indicate if the client received PrEP mediation
 - If yes, a new field will become available.

Section 13: Prevention Testing Only: PrEP Adherence

| PrEP Adherence | |
|--|--|
| Did you provide individual medication adherence counseling sessions? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| reset | |
| Date of medication adherence counseling session 1 | <input type="text"/>  Today D-M-Y |

- 1) Did you provide individual medication adherence counseling sessions?
 - Indicate if you provided you client with medication adherence counseling.
- 2) Date of medication adherence counseling session 1
 - Indicate the date of the adherence counseling session. Up to six adherence session dates can be entered.

Section 14: Prevention Testing Only: PrEP Counseling

| PrEP Counseling | |
|---|--|
| Did client receive group counseling? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| reset | |
| Date of group counseling session 1 | <input type="text"/>  Today M-D-Y |
| Did you provide serodiscordant couple counseling sessions for PrEP? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| reset | |
| Date of couple counseling session 1 | <input type="text"/>  Today M-D-Y |

- 1) Did client receive group counseling?
 - Indicate if you provided you client with group counseling.
 - If yes, a new field will become available.
- 2) Date of group counseling session 1
 - Indicate the date of the adherence counseling session. Up to six group session dates can be entered.
- 3) 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.
- 4) Date of couple counseling session 1
 - Indicate the date of the couple counseling session. Up to six couple session dates can be entered.

Section 15: nPEP Services

nPEP Services

Did you provide referral services for nPEP?

☐ Yes
☐ No

reset

1) Did you provide referral services for nPEP?

- Indicate if you provided referral services for nPEP.
- If yes, three new fields will become available.

Did you link client to nPEP education, including assessment of need?

☐ Yes
☐ No

reset

Did you link client to an nPEP clinical visit?

☐ Yes
☐ No

reset

Did client receive nPEP medication

☐ Yes
☐ No

reset

- 2) Prevention Testing Only: Did you link client to nPEP education, including assessment of need?
- Indicate if you linked your client to nPEP education, including assessment of need
- 3) Prevention Testing Only: Did you link client to an nPEP clinical visit?
- Indicate if you linked your client to an nPEP clinical visit.
- 4) Prevention Testing Only: Did client receive nPEP medication?
- Indicate if the client received nPEP medication.

Section 16: Pregnancy Reporting

Pregnancy Reporting

Is the patient engaged in obstetrical care?

Expected Due Date

* must provide value

Yes
No
Unknown

Today M-D-Y

1) 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.**


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DC | HEALTH

Pregnancy Reporting

Is the patient engaged in obstetrical care?

Expected Due Date
* must provide value

 Today M-D-Y

Calendar dropdown showing Jan 2019:

| Su | Mo | Tu | We | Th | Fr | Sa |
|----|----|----|----|----|----|----|
| | | | | | | |
| | | | | 2 | 3 | 4 |
| 6 | | | | 9 | 10 | 11 |
| 13 | | | | 16 | 17 | 18 |
| 20 | | | | 23 | 24 | 25 |
| 27 | | | | 30 | 31 | |
| | | | | | | |

2) 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 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.**

Pregnancy Reporting

Is the patient engaged in obstetrical care?

Expected Due Date
* must provide value

 Today M-D-Y

Anticipated Delivery Hospital

3) Anticipated Delivery Hospital

- Indicate the client’s anticipated delivery hospital.

Has the patient been previously diagnosed with any of the following:

☐ Hepatitis B

☐ Hepatitis C

☐ HIV

☐ Syphilis

Is the patient engaged in specialist care?

4) Has the patient been previously diagnosed with any of the 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?”

| | |
|---|---|
| Has the patient been previously diagnosed with any of the following: | <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis |
| Is the patient engaged in specialist care? | <div> <input type="text" value=""/> <ul style="list-style-type: none"> Yes No Unknown </div> |
| Do you suspect problems with any of the following in your patient (check all that apply): | <input type="checkbox"/> Adherence <input type="checkbox"/> .. |

5) Is the patient engaged in specialists care?

- Indicate if the patient is in specialist care from the drop down menu.

| | |
|--|---|
| Do you suspect problems with any of the following in your client (check all that apply): | <input type="checkbox"/> Medication Adherence <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Risk/History of falling out of care |
|--|---|

6) 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.

Section 17: Prevention Testing Only: Session Activities

| Session Activities | |
|--------------------------------------|----------|
| Session Activities | Referral |
| If applicable, add another activity: | |

1) Session Activities

- Indicate any associated activities that are related to the HIV testing event. For example, harm reduction counseling, condom usage, etc.
- If applicable, add another activity. You will able to add up to three additional activities (for a total of 4 session activities).

Section 18: Comments

| Comments |
|--|
| <p>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, alternate addresses or information that requires immediate follow up.</p> <div></div> <div>Expand</div> |

- 1) 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, alternate addresses or information that requires immediate follow up.

Section 19: Submit and Save Later



Submit

Save & Return Later

- 1) Submit
 - After you have completed your case report form, please click the submit button to send the case report form to DC Health.



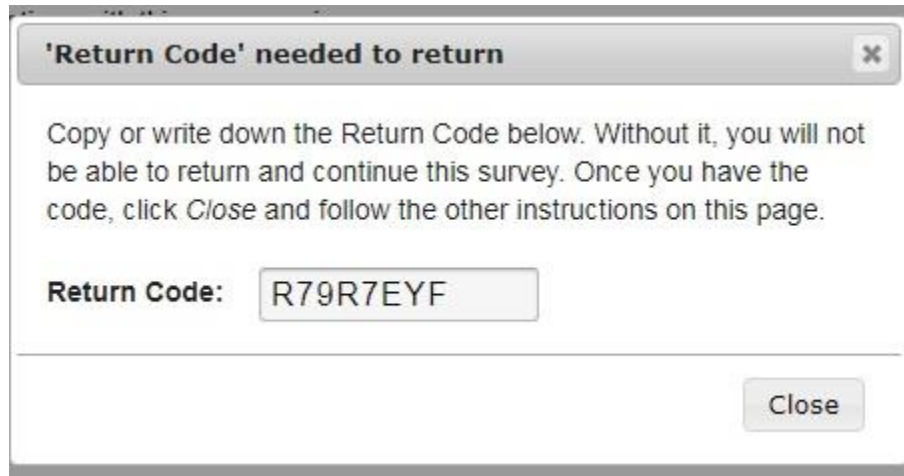
- If you are missing any field, the system will not allow you to submit the case report form and will indicate which field needs to be updated.



Submit

Save & Return Later

- 2) Save and Return Later
 - In the event you need to stop filling out this form and would like to save your work to return later, please click on the "Save & Return Later" button.



3) 'Return Code' Needed to Return

- When you click on the "Save & Return Later" button, you will be greeted with a unique code that you can input when you are able to complete the form. It is important that you retain this code to continue where you left off in the case report form. If you do not retain the return code, you will need to start back at the beginning of the form. **This window will only appear if you clicked the "Save & Return Later" button.**
- The return code is a random generated code and will change for each additional case report form that you fill out.

Your survey responses were saved!

You have chosen to stop the survey for now and return at a later time to complete it. To return to this survey, you will need both the *survey link* and your *return code*. See the instructions below.

1.) Return Code

A return code is ***required*** in order to continue the survey where you left off. Please write down the value listed below.

Return Code

* The return code will NOT be included in the email below.

2.) Survey link for returning

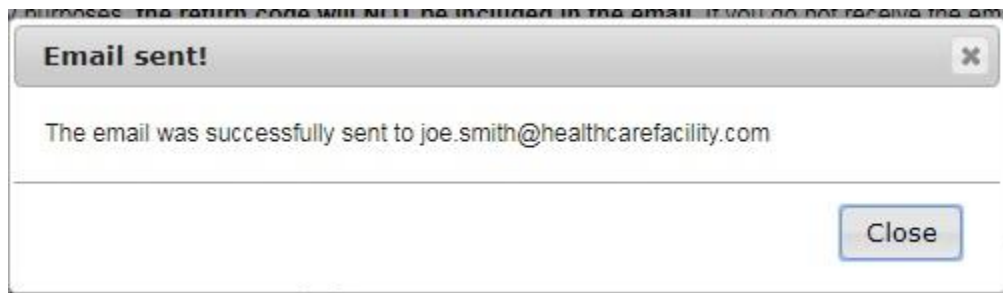
You may bookmark this page to return to the survey, OR you can have the survey link emailed to you by providing your email address below. For security purposes, **the return code will NOT be included in the email**. If you do not receive the email soon afterward, please check your Junk Email folder.

* Your email address will not be stored

Or if you wish, you may continue with this survey again now.

4) Your survey responses were saved!

- When you click close on the “Return Code Needed to Return” box, you will be greeted with this page. This page displays the unique return code and the opportunity to send the survey link to your emails address. **In order to return to where you left off on the case report form, you need the survey link AND the return code.** It is highly recommended that you send the survey link to your work emails address. **Sending the survey link to you work email WILL NOT have a copy of the return code.**



5) Email Sent!

- Once you input your work email address, you will be greeted with this screen.

Reply Reply All Forward



Wed 11/14/2018 11:43 AM

redcap.epi.doh@dc.gov

Survey partially completed

To joe.smith@healthcarefacility.com

[This message was automatically generated.]

Thank you for partially completing the survey "". You may continue your progress on this survey by clicking the link below. You will need your return code that was given to you on the survey webpage.

If the link above does not work, try copying the link below into your web browser:

https://redcap.doh.dc.gov/surveys/index.php/surveys/?s=9W4F3W8YTD&__return=1

6) Email from REDCap

- The email will be sent you work email address. Click the link provided in the email address and your preferred web browser will automatically take you to the REDCap Return Code web page.

← → ↻ Government of the District of Columbia [US] | <https://redcap.doh.dc.gov/surveys/index.php/surveys/?s=9W4F3W8YTD>

DC | HEALTH

Resize font: [Returning?](#)

HIV/AIDS, Hepatitis, STD, and TB Administration

Testing and Case Report Form

For questions regarding reporting publicly funded HIV, Viral Hepatitis, STD, and TB tests please contact us via phone at 202-671-5055

For questions regarding reporting of HIV, Viral Hepatitis, STD, and TB cases please contact us via phone at 202-671-4900 or via email at HAHSTA.CaseReport@dc.gov

7) Returning?

- If you misplace your REDCap link or did not send the link to your email, you can still reach the REDCap Return Code page by proceeding to REDCap website and clicking on "Returning" in the top right hand corner of the web page.



To continue the survey, please enter the RETURN CODE that was auto-generated for you when you left the survey. Please note that the return code is *not* case sensitive.

Submit your Return Code

8) REDCap Return Code page

- Input your Return Code in the field and click “Submit your Return Code” to return to your case report form. Please note that the Return Code is not case sensitive.