Rev. 4/27/2018

HAHSTA

(HIV/AIDS, Hepatitis, STD, and TB Administration)

Case Report Form Technical Guidance for HIV/AIDS, Viral Hepatitis, and Sexually Transmitted Infections

DC | HEALTH

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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, and sexually transmitted infections (syphilis, gonorrhea, and chlamydia) 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.

The Case Report Form

The HAHSTA Notifiable Disease Report Form should be completed in its entirety to report all new cases of HIV/AIDS, Hepatitis and Sexually Transmitted Infections within the District of Columbia. The one page form is divided into five 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 as a fillable PDF document or standard PDF file. The fillable PDF can be pre-populated with the Health Provider Information and saved on a computer. You can hover the mouse/cursor over a field to see a hint on what information is expected. The Standard PDF forms should be completed in blue or black ink only. Print neatly and use capital letters if possible. Do not use cursive. To be determined at a future date, an Internet-based form that complies with HIPAA will be made available and allow direct submission to the health department.

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 form in REDCap, it is electronically transferred to the health department.

2) Facsimile transmission -to secured line ONLY at 202-727-4934. 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

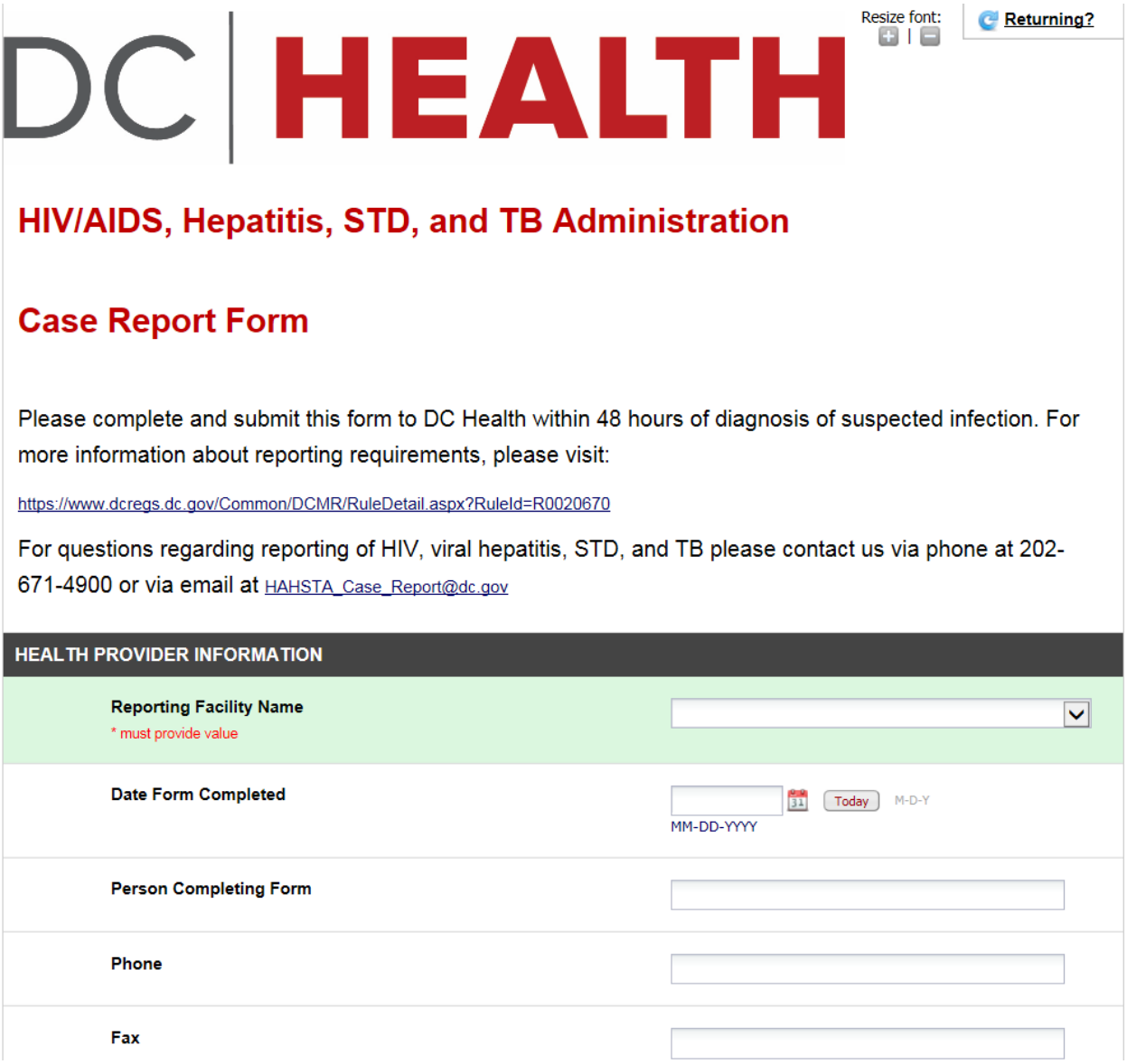
4) Hand Delivered- Forms can be hand delivered to the above address during regular business hours (8:15AM to 4:45PM).

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

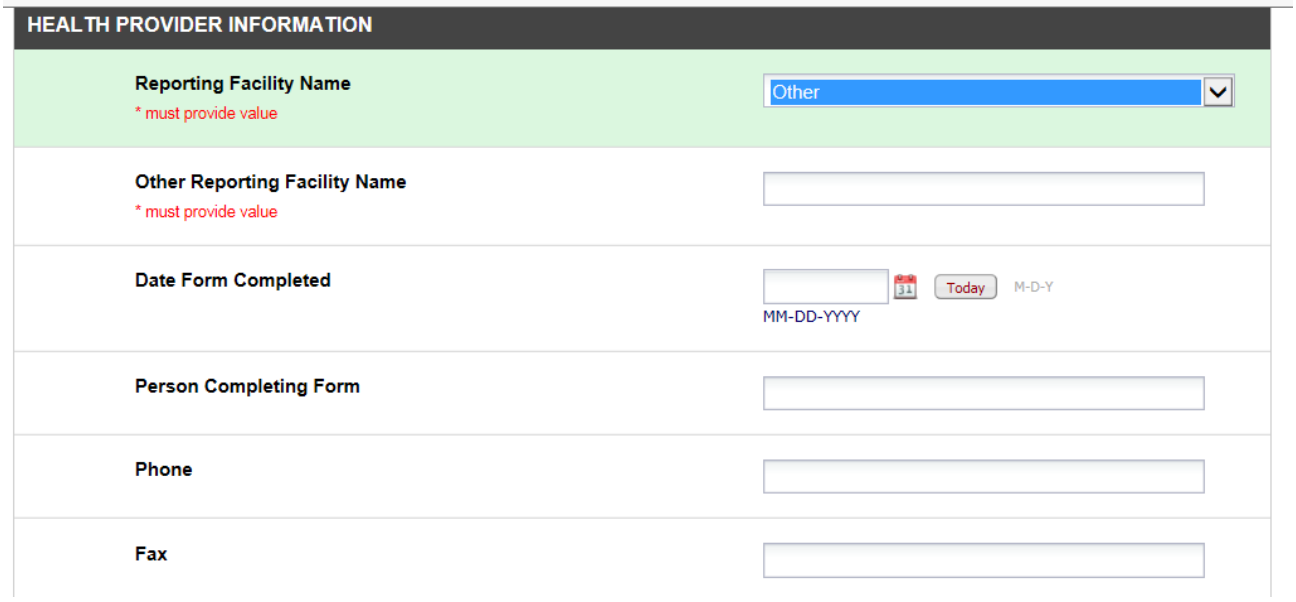
Completing the Form

Section 1: Health Provider Information

This section reports the information for health provider entity completing the form.



1) Reporting Facility Name
   - Enter the name of the facility, practice, or organization reporting the case to the health department.
   - If facility has more than one location or separate department for testing and reporting be sure to specify.



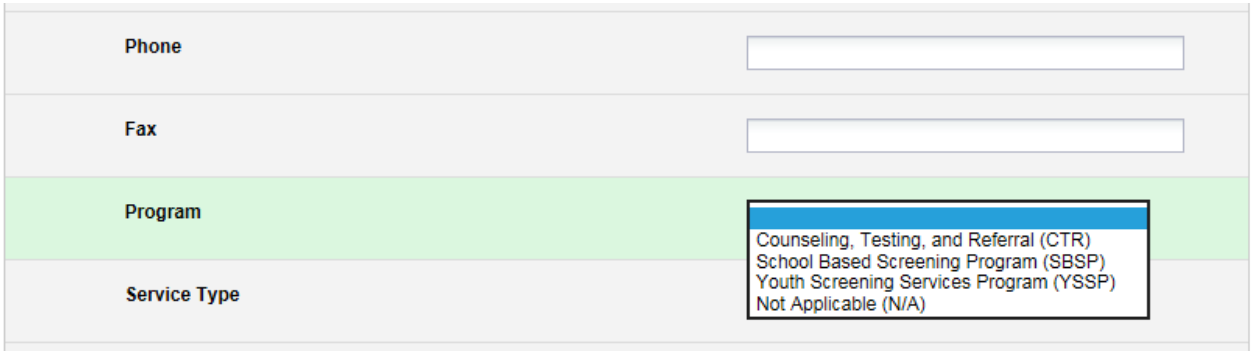
2) Other Reporting Facility
   - If "Other" is selected for Reporting Facility Name, the facility name must be entered here.

3) Date Form Completed:
   - Date in which the form is completed
   - May differ from the date the information was collected.

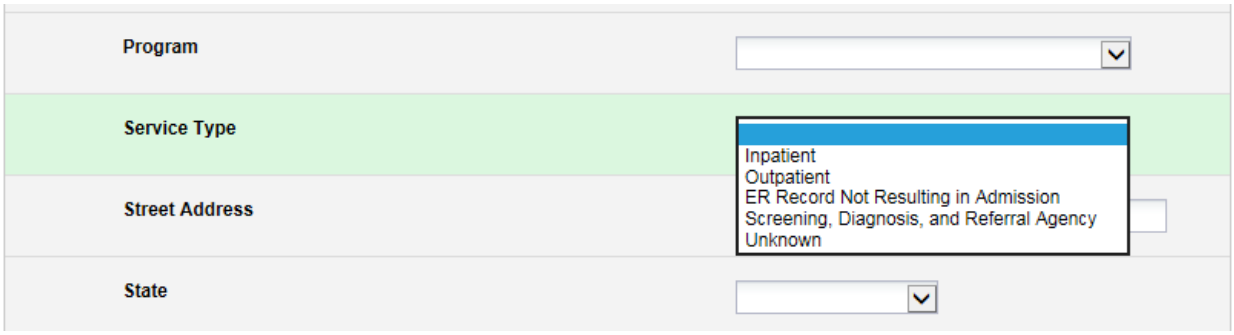
4) Person Completing Form:
   - First and last name of the person who completed the form
   - This should be the designated person responsible for the information provided and may differ from the person who collected the information

5) Phone:
   - Record the telephone number of the person completing the form.

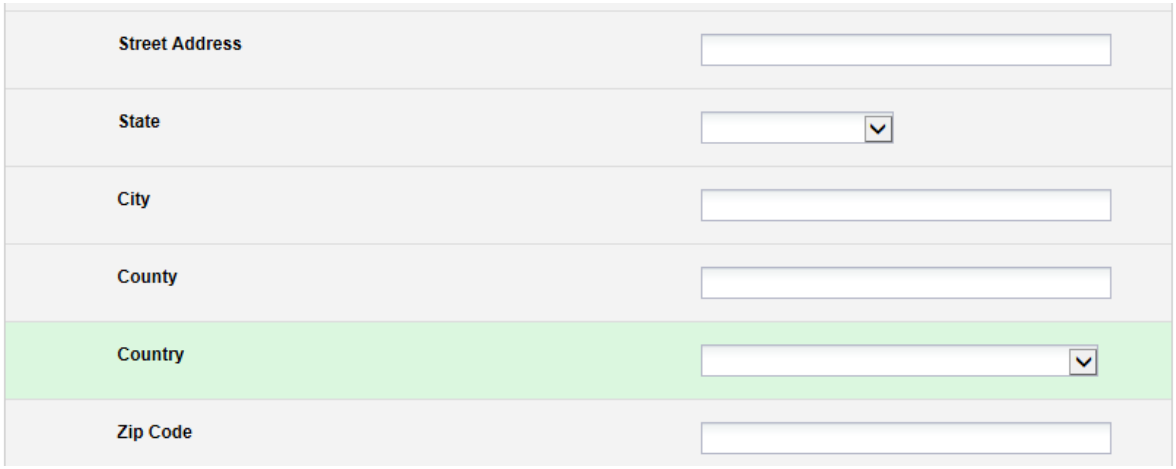
6) Fax
   -



7) Program:
    - Select the program under which the diagnosis occurred
        - CTR- Counseling, Testing, and Referral Program (HIV Prevention)
        - SBSP- School Based Screening Program (STD Control)
        - YSSP- Youth STI Screening Program (STD Control)
        - N/A- Check this box if the diagnoses did not occur as a part of any of the aforementioned programs.



8) 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



1) Current Street Address:
    - Enter the facility’s current street number and name.

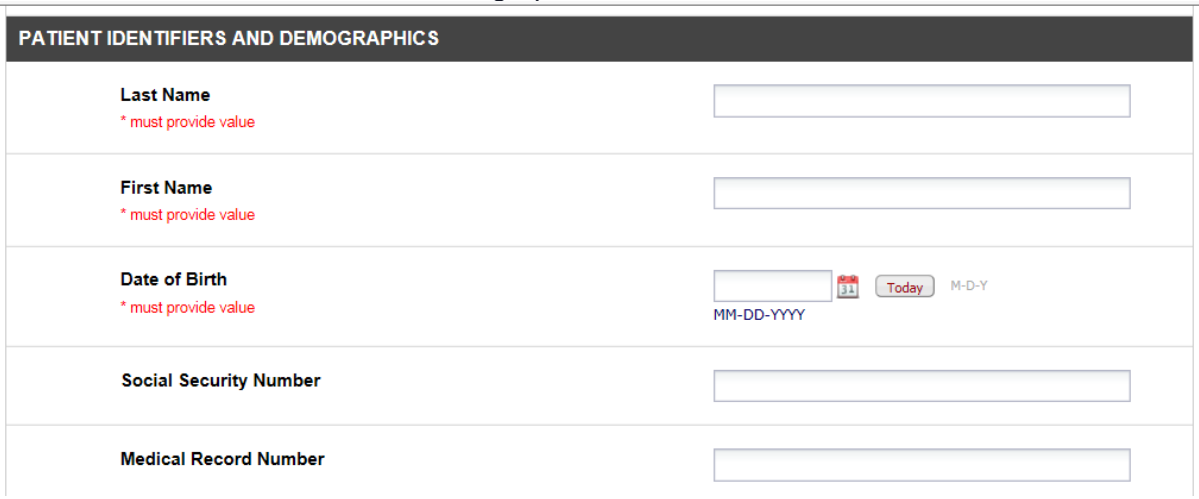
2) State:
    - Enter facility’s current state.
    - If the selected state is “District of Columbia”, ward will become available
    - If the selected state is not “District of Columbia, county will remain available

3) City:
    - Enter the facility’s city.

4) County/Ward:
    - Enter the facility's county or ward
        - If the facility's is in the District of Columbia, please enter the ward
        - If the facility's is outside of the District of Columbia, please enter the county

5) ZIP Code:
    - Enter the facility's ZIP code.

Section 2: Patient Identifiers and Demographics



Patient Demographics are recorded in this section of the form.

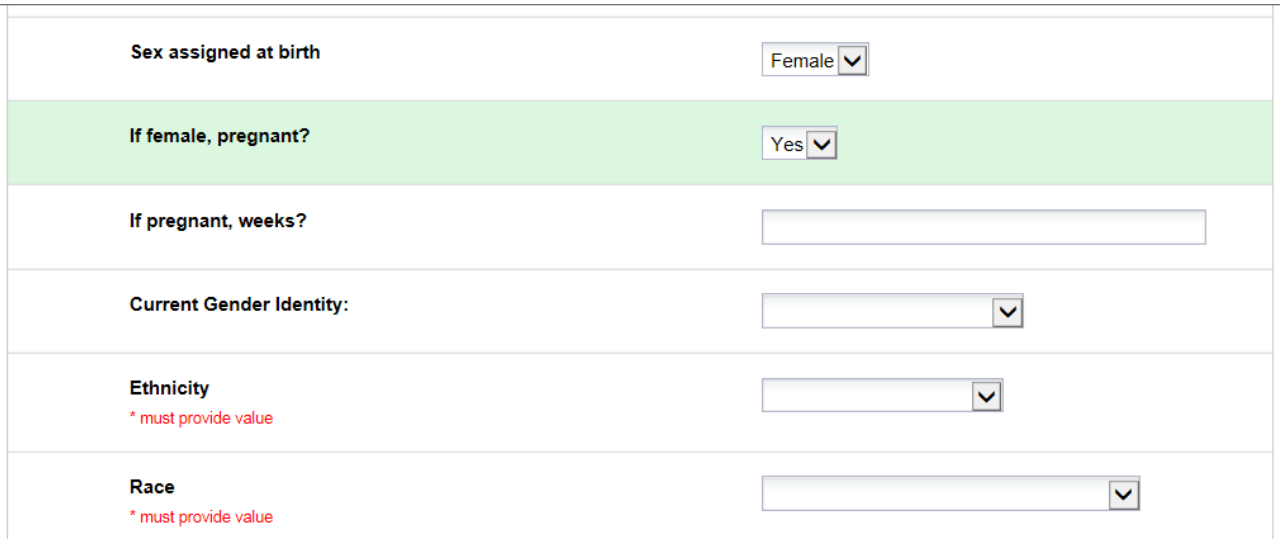
6) Last Name:
    - Enter the last name of the patient

7) First Name:
    - Enter the first name of the patient

8) Date of Birth:
    - Enter the date of birth of the patient

9) Social Security Number
    - Enter the 9-digit social security number for the patient
        - If all nine digits are not known, enter the last four digits in the last space
        - If the patient does not have a social security number, please leave the field blank.

10) Medical record number:
    - Enter the medical record number used to identify the patient at the reporting facility
        - If the patient does not have a medical record number, please leave the field blank



11) Sex at Birth:
- Enter the sex assigned at birth for the patient
  - This may differ from the gender identity of the patient.
  - If sex assigned at birth is “female”, pregnancy status becomes available

12) Pregnant
- If patient is female, is the patient pregnant

13) If pregnant, how many weeks:
- If the patient is pregnant, please enter the number of gestational weeks.

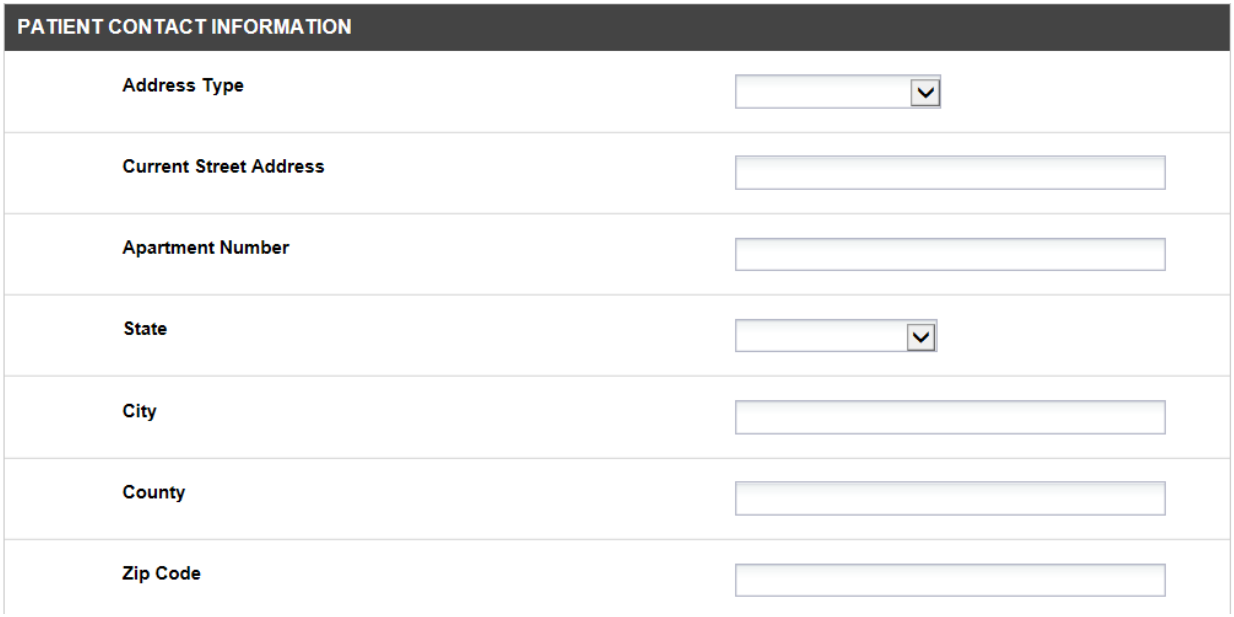
14) Gender Identity:
- Enter the gender identified by the patient

15) Ethnicity:
- Enter the applicable response
  - If no ethnicity information is available, select Unknown. This generally is related to whether or not the patient’s lineage includes a Spanish speaking country.

16) Race:
- Enter all applicable selections (persons may identify with multiple races)
  - This question should be answered even if information was entered for ethnicity
  - If no race information is available, select Unknown

Section 3: Patient Contact Information

This section is used to record the contact information for the patient being reported. This information can be used by the DOH to contact the patient to conduct a partner services interview.



17) Address type:
- Patient's current residential address.
  - **Residential**- patient is currently residing at the address listed.
  - **Correctional Facility**- patient is currently residing within a correctional facility.
  - **Foster Home**- patient is residing in a foster home.
  - **Homeless**- patient 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**- patient is currently residing in a shelter home.
  - **Temporary**- 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. 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/.

18) Current Street Address:
- Enter the patient's current street number and name.

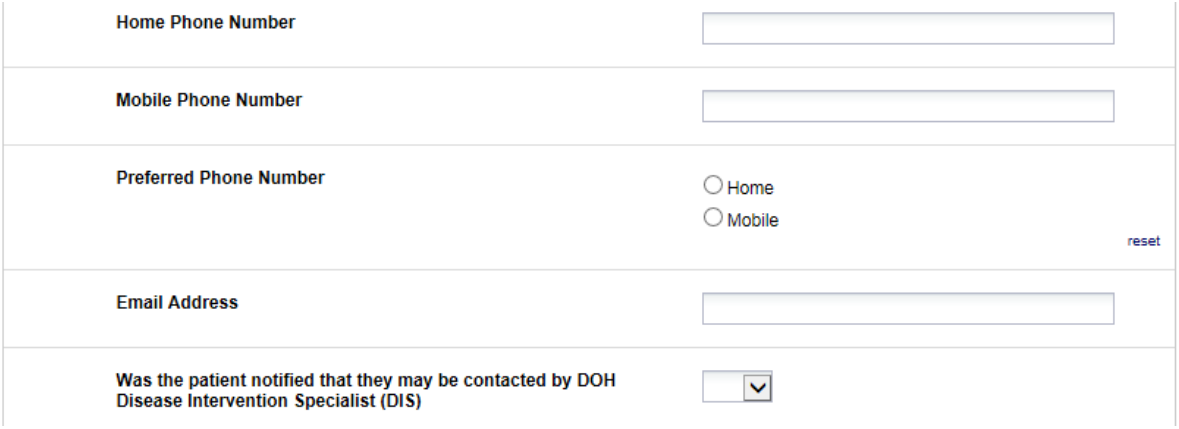
19) Apartment number:
- If apartment number is not applicable, please leave it blank.

20) State:
- Enter patient's current state of residence.
- 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

21) City:
- Enter the city of the patient's current residential address.

22) County/Ward:
- Enter the county or ward of the patient's current residential address
  - If the patient's residence is in the District of Columbia, please enter the ward
  - If the patient's residence is outside of the District of Columbia, please enter the county

23) ZIP Code:
- Enter the patient's ZIP code.



24) Home Phone Number:
- Enter the patient's current home phone number, if applicable.
  - If phone number is unknown, please leave it blank.

25) Mobile Phone Number:
- Enter the patient's current mobile phone number, if applicable.
  - If phone number is unknown, please leave it blank.

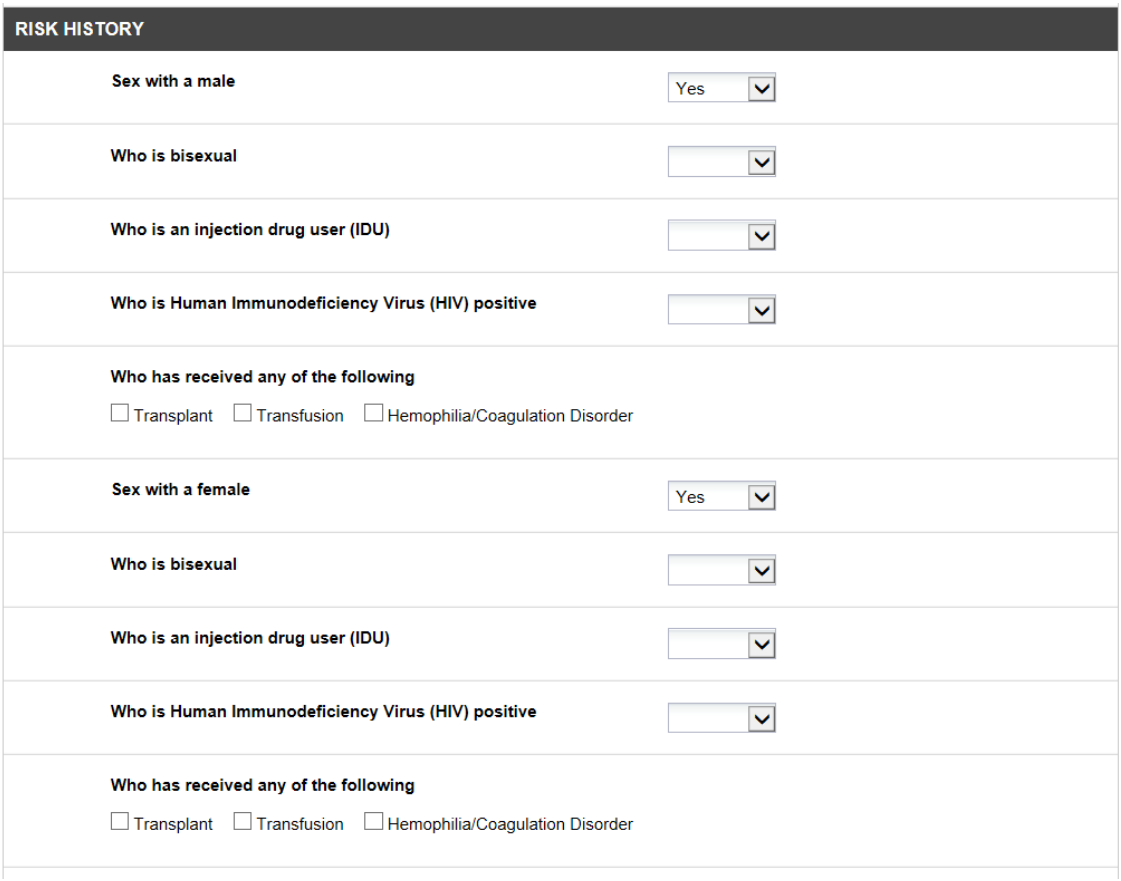
26) Preferred Phone Number
- Select which phone number the patient's would prefer to be contacted using.

27) Email Address:
- Enter the patient's preferred email address, if applicable.
  - If email address is unknown, please leave it blank.

28) DOH Disease Intervention Specialists (DIS):
- Select Yes if the patient was notified that they may be contacted by a Disease Intervention Specialist from the DC DOH.
- Otherwise select No

Section 4: Risk History

The section records the risk history of the patient. This information allows the health department to best understand how the aforementioned diseases are being transmitted in the population and informs programmatic activities in the District.

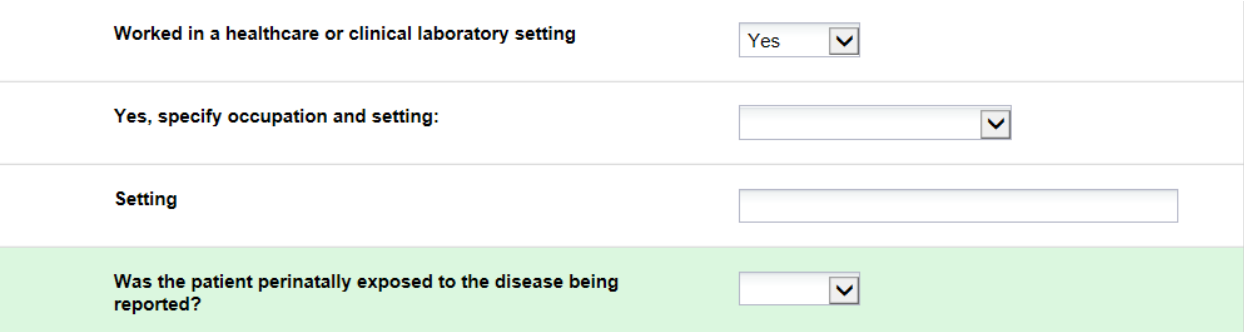


1) Sex with Male:
- Select whether the patient has had sex with a male:
  - If yes, select if the patient has had sex with a male who is:
    1. Bisexual
    2. Injection Drug User
    3. HIV Positive
    4. Other Risks: Transplant, Transfusion, Hemophilia/Coagulation Disorder
  - If not known, select unknown

2) Sex with Female:
    - Select whether the patient has had sex with a female:
        - If yes, select if the patient has had sex with a female who is:
            1. Bisexual
            2. Injection Drug User
            3. HIV Positive
            4. Other Risks: Transplant, Transfusion, Hemophilia/Coagulation Disorder
        - If not known, select unknown

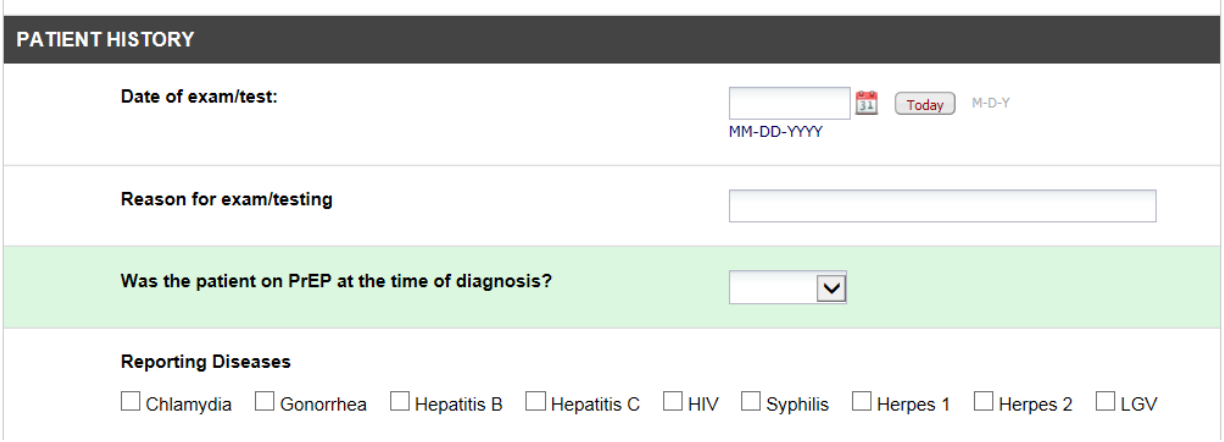
3) Injected Non-prescription Drugs
    - If you know whether or not the patient is has injected non-prescription drugs, please check the corresponding response of Yes or No. If you did not ask about the patient's activity with IDU, please select Unk.

4) Occupational Risk:
    - Select whether the patient has worked in healthcare or clinical laboratory setting.
        - If so, please specify the patient's occupation and setting



5) Perinatal Exposure
    - Enter Yes if the patient was perinatally exposed to the disease(s) being reported
    - Enter No if the patient was NOT perinatally exposed to the disease(s) being reported
    - If the patient's exposure status is unknown, please leave it blank.

Section 5: Patient History



1) Date of Exam:
   - Enter the date the exam (visit) leading to the diagnosis was conducted

2) Reason for Exam:
   - Enter the patient's chief complaint or reason for the exam.
     - Example: annual sexual transmitted disease testing, fatigue, sore throat, fever etc.

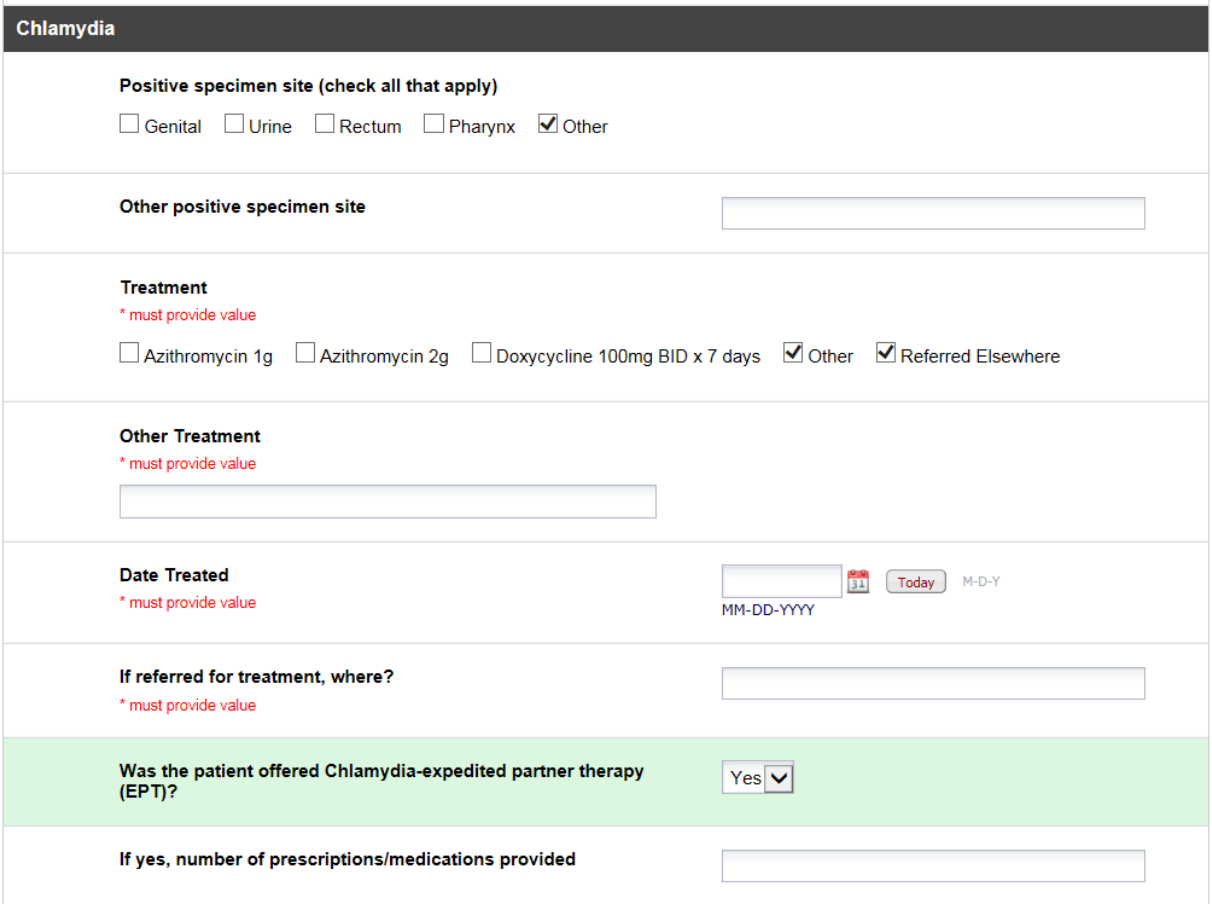
3) Pre-Exposure Prophylaxis (PrEP)
   - Enter Yes if the patient is currently taking antiretroviral medication (i.e., Truvada) as PrEP.
   - Enter No if the patient is NOT currently taking antiretroviral medication as PrEP.
   - If the patient's current PrEP use is unknown, please leave it blank.

4) Reporting Diseases
   - Please check all diseases currently being reported to DOH.
   - As diseases are checked, additional questions will become available.

Section 6: Diagnosis and Treatment

The diagnosis section of this form is reserved for STD, HIV and Hepatitis testing and treatment information. For new cases of chlamydia, gonorrhea, and syphilis site of infection and treatment information should be identified. Treatment information includes date treated and treatment regimen. In the case of co-infection, all diseases, diagnosis and treatment regimens should be listed.

Chlamydia



1) Site:
   - Select the site or sites of infection for chlamydia
     - If the site is not listed, select other and write in the specific site

2) Other positive specimen site:
   - Please write in any specimen sites not included above

3) Treatment:
   - Select one of the available treatment options
     - If other is selected, please enter the specific treatment regimen prescribed
     - If referred elsewhere is selected, please enter the specific location the patient was referred

4) Other Treatment:
   - Please indicate which treatment regimen was used to treat the infection

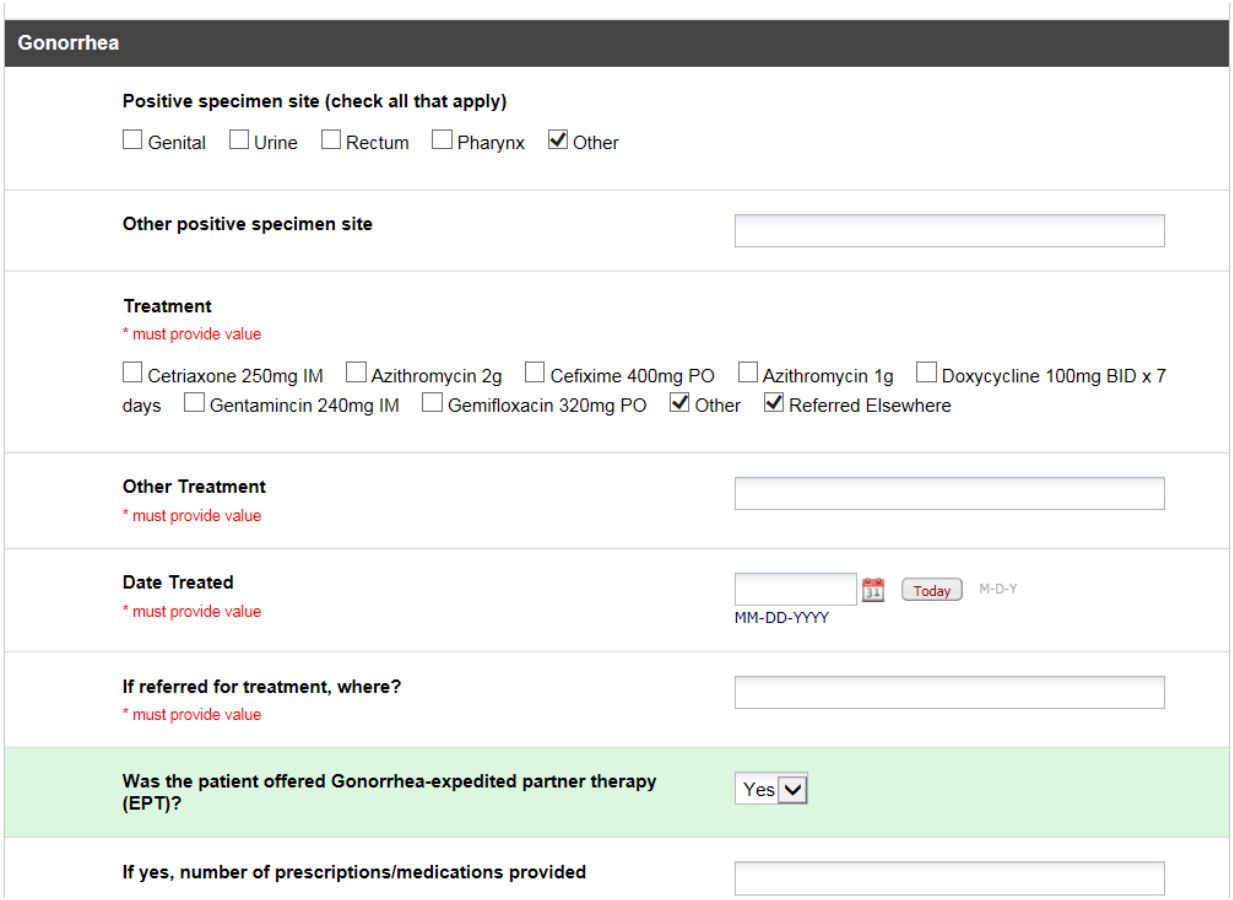
5) Date Treated:
   - Enter the date treatment was initiated

6) If Referred for Treatment, Where?
   - Please indicate the specific location the patients was referred to for treatment

7) Partner Medication/Prescriptions:
    - Please indicate by selecting the appropriate response of Yes or No

8) Number of prescriptions/medications:
    - Please indicate the number of medications and/or prescriptions given to the patient for their partner(s).

Gonorrhea



1) Site:
    - Select the site or sites of infection for gonorrhea
        - If the site is not listed, select other and write in the specific site

2) Other positive specimen site:
        - Please write in any specimen sites not included above

3) Treatment:
    - Select one of the available treatment options
        - If other is selected, please enter the specific treatment regimen prescribed
        - If referred elsewhere is selected, please enter the specific location the patient was referred

4) Other Treatment:

- Please indicate which treatment regimen was used to treat the infection

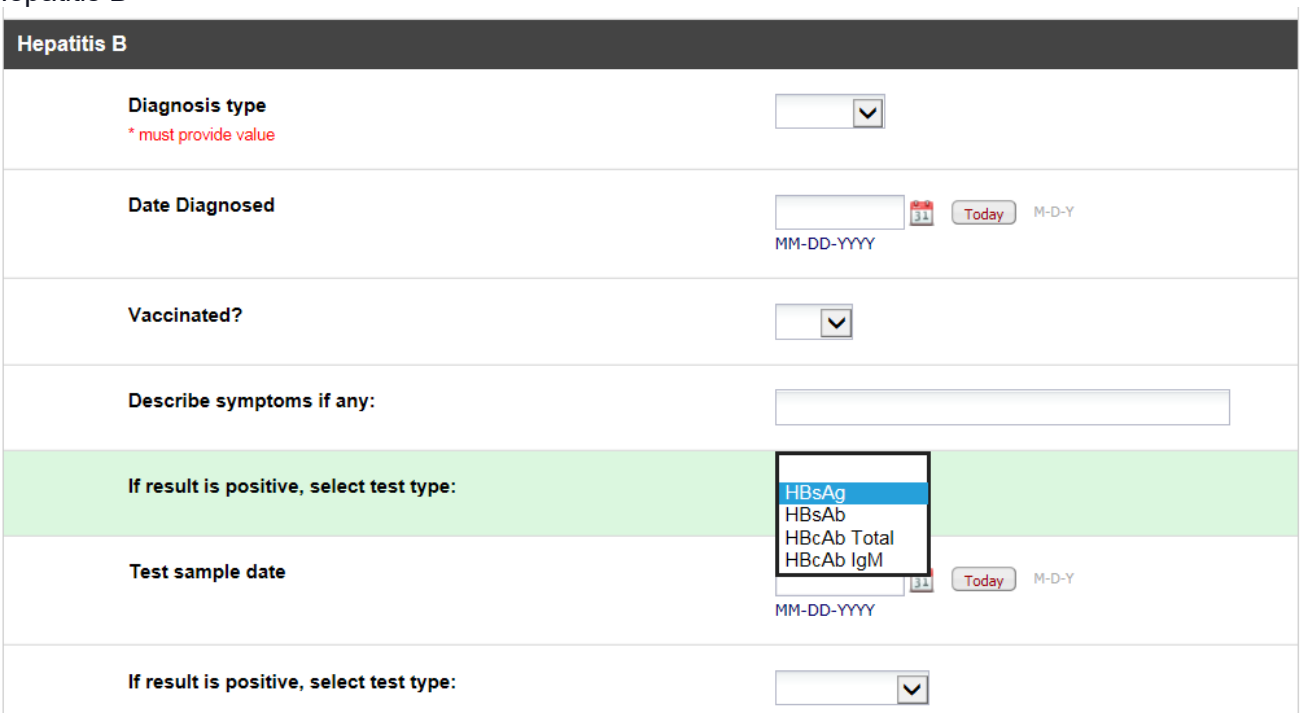
5) Date Treated:
   - Enter the date treatment was initiated

6) If Referred for Treatment, Where?
   - Please indicate the specific location the patients was referred to for treatment

7) Partner Medication/Prescriptions:
   - Please indicate by selecting the appropriate response of Yes or No

8) Number of prescriptions/medications:
   - Please indicate the number of medications and/or prescriptions given to the patient for their partner(s).

Hepatitis B



1) Diagnosis Type:
   - Past- diagnosis occurred prior to the reporting of this document
   - Current- diagnosis occurred in conjunction with the reporting of this document

2) Date Diagnosed:
   - Enter the date the patient was diagnosed with Hepatitis B

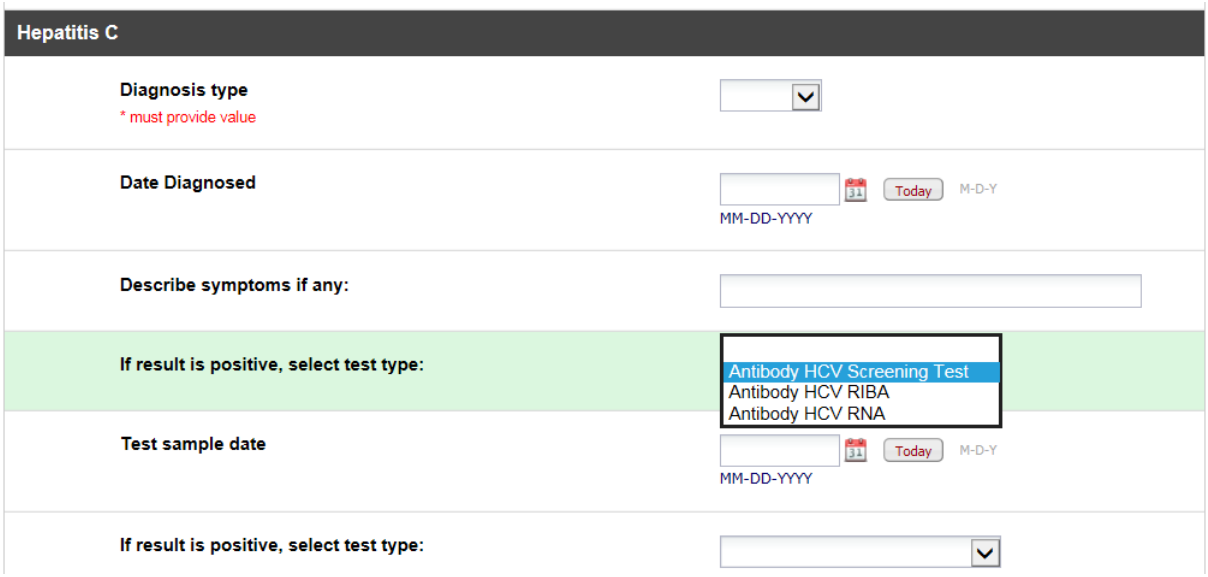
3) Vaccination:
   - Check the box if the patient was vaccinated for hepatitis B
     - If vaccination has not been provided, please leave it blank

4) Describe Symptoms:
    - Please document identified signs and symptoms reported in relation to Hepatitis B

5) Test:
    - Select an applicable test for which the patient tested positive
        - Additional reporting fields will become available as tests are selected.

1) Date Tested:
    - Enter the date the test was conducted

Hepatitis C



1) Diagnosis Type:
    - Past- diagnosis occurred prior to the reporting of this document
    - Current- diagnosis occurred in conjunction with the reporting of this document

2) Date Diagnosed:
    - Enter the date the patient was diagnosed with Hepatitis C

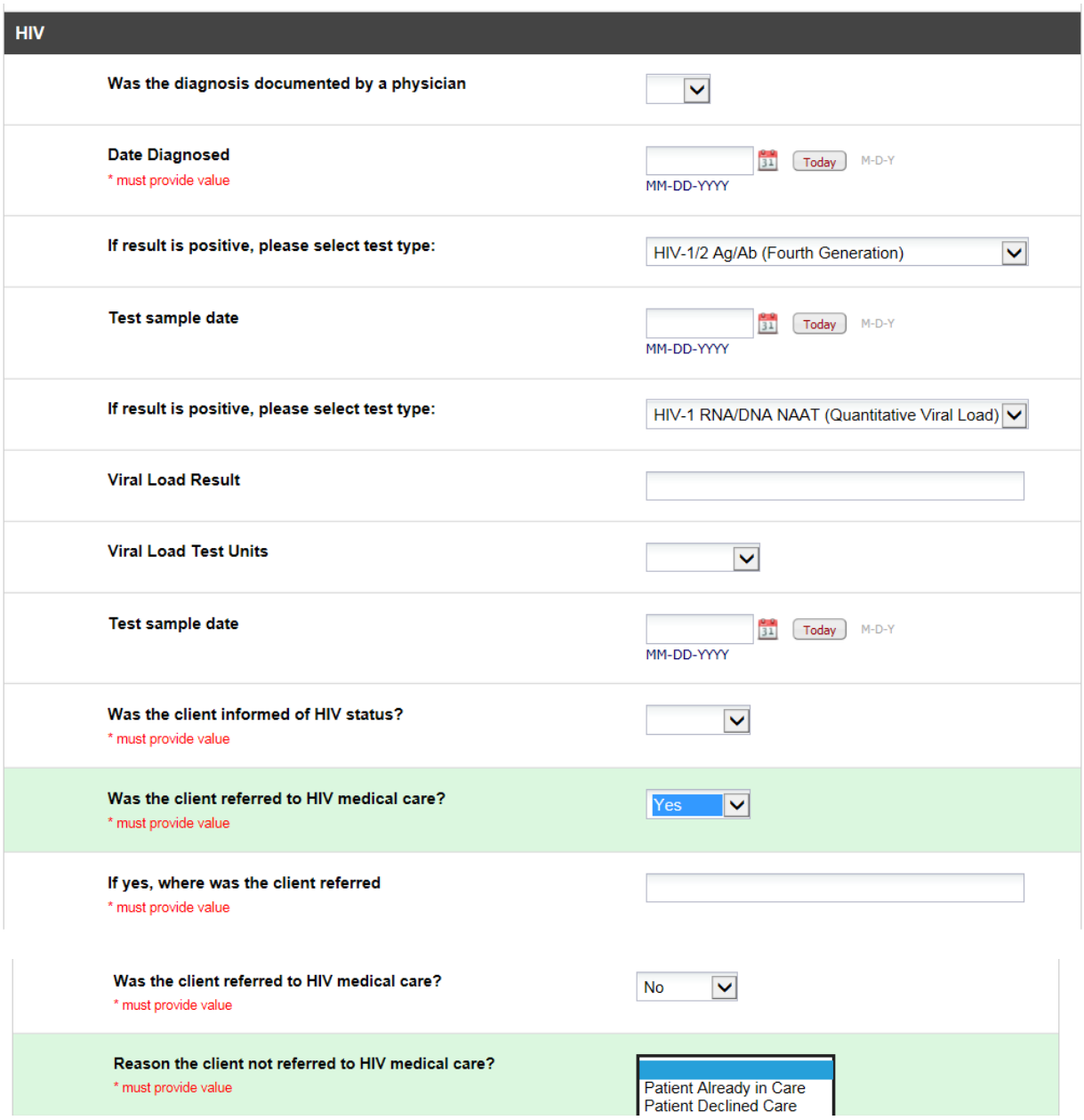
3) Vaccination:
    - Check the box if the patient was vaccinated for hepatitis C
        - If vaccination has not been provided, please leave it blank

4) Describe Symptoms:
    - Please document identified signs and symptoms reported in relation to Hepatitis C

5) Test:
    - Select an applicable test for which the patient tested positive
        - Additional reporting fields will become available as tests are selected.

6) Date Tested:
    - Enter the date the test was conducted

Human Immunodeficiency Virus (HIV)



1) Physician Diagnosis:
   - Select Yes if laboratory evidence of an HIV diagnosis is unavailable and written documentation of lab evidence is consistent with the case definition
   - Otherwise select No.

2) Date Diagnosed:
   - Enter the date the patient was diagnosed with HIV (earliest known positive date)

3) Test:
    - Select each applicable test
    - If HIV-1 RNA/DNA NAAT (Quantitative Viral Load) is selected enter the test result and units of the test.

4) Test Sample Date
    - Enter the date the sample was collected for the test.

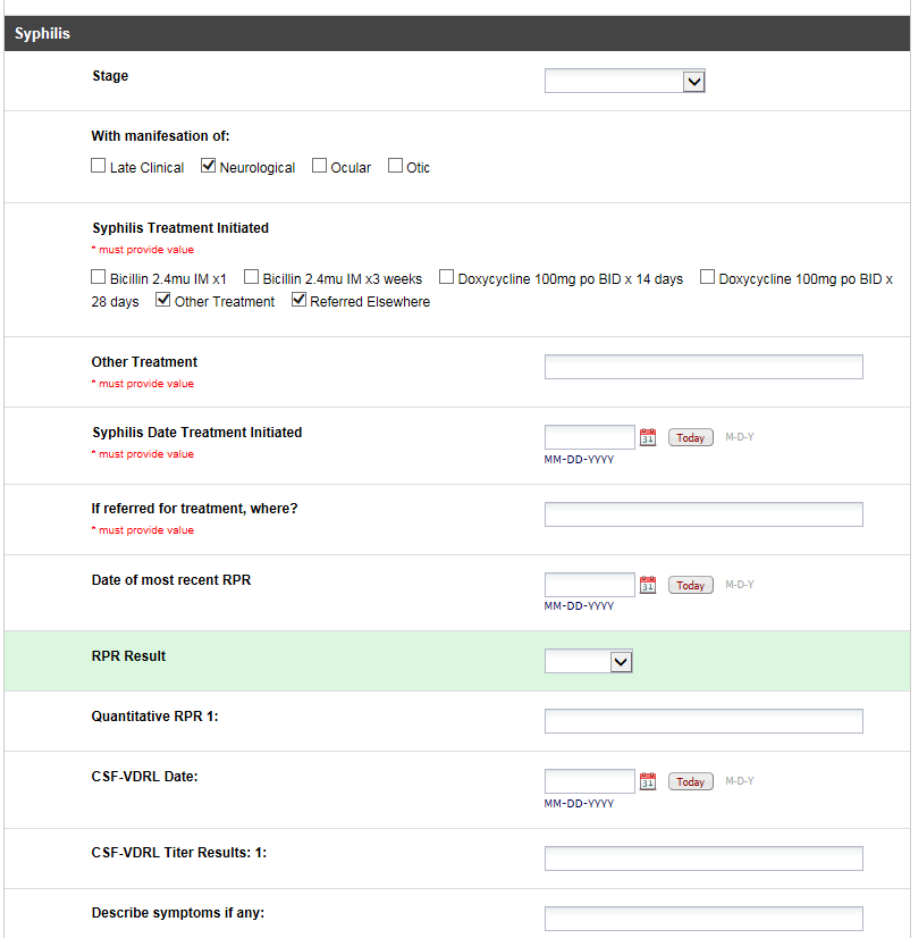
5) Patient Informed of Status:
    - Select the applicable response

6) Referred to Care:
    - Select the applicable response
        - If the client was referred to care, please enter the location
            - If the facility completing the form is the same as the diagnosing facility, Check the box indicating, SAME as the Reporting Facility

7) If you check Yes to the Referred to Care question, please check the appropriate response to whether or not the appointment to the care facility was verified by you, the reporting facility.

8) If you check No to the Referred to Care question, please select the reason the person was not referred to care.

Syphilis



1) Stage at Diagnosis:
    - Select the most applicable stage at diagnosis

2) Syphilis associated manifestations:
    - Check the appropriate box if there were late clinical, neurologic, ocular, or otic manifestations with the syphilis infection

3) Syphilis Treatment Initiated
    - If treatment was initiated, please select which one.
    - If other is selected, please enter the specific treatment regimen prescribed
    - If referred elsewhere is selected, please enter the specific location the patient was referred

4) Other Treatment
    - If treatment an alternative same day treatment regime was offered, please specify

5) If Referred for Treatment, Where?
    - Please indicate the specific location the patients was referred to for treatment

6) Date of most recent RPR
    - Please document the date of the most recent RPR on record

7) RPR Result
    - If the RPR was qualitative, please select the appropriate result

8) Quantitative RPR:
    - If the RPR was quantitative, please provide the dilution value
        - The “1:” portion is already included

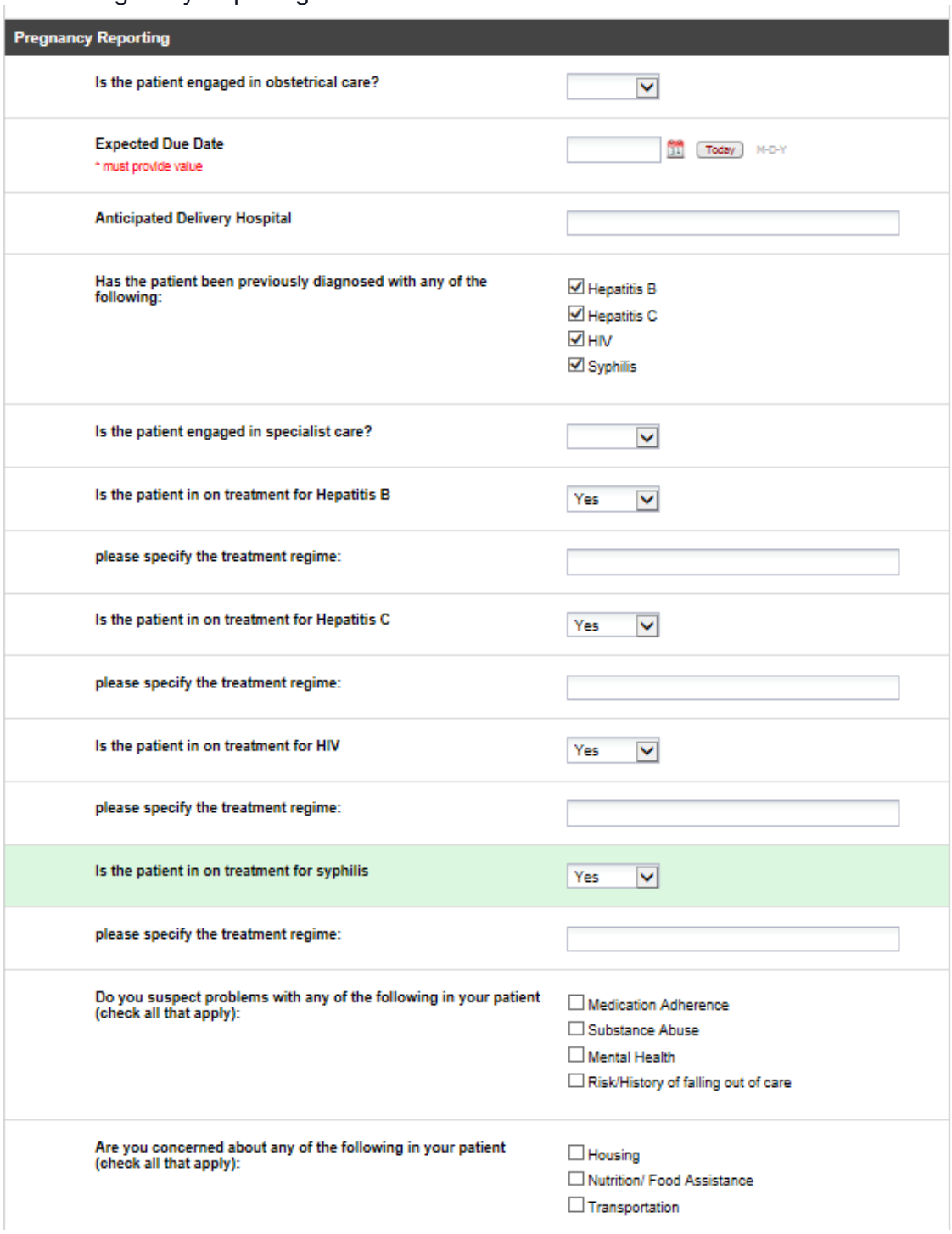
9) Describe Symptoms:
    - Please enter all symptoms reported by the patient in relation to syphilis

10) Date of CSF-VDRL:
    - Please document the date of the CSF-VDRL on record

11) CSF-VDRL Titer Result:
    - please provide the dilution value
        - The “1:” portion is already included

12) Describe Symptoms:
    - Please enter all symptoms reported by the patient in relation to syphilis

Section 7: Pregnancy Reporting



1) Engaged in obstetrical care:
    - Please indicate whether the patient is engaged in obstetrical care or not

2) Expected Due Date
    - Please indicate the expected due date of the patient

3) Anticipated Delivery Hospital
    - Please indicate the anticipated delivery hospital for the patient

4) Previous Diagnosis
    - Please indicated which diseases the patient was previously diagnosed with

5) Engaged in Specialist Care
    - Please identify whether the patient is engaged in specialist care or not

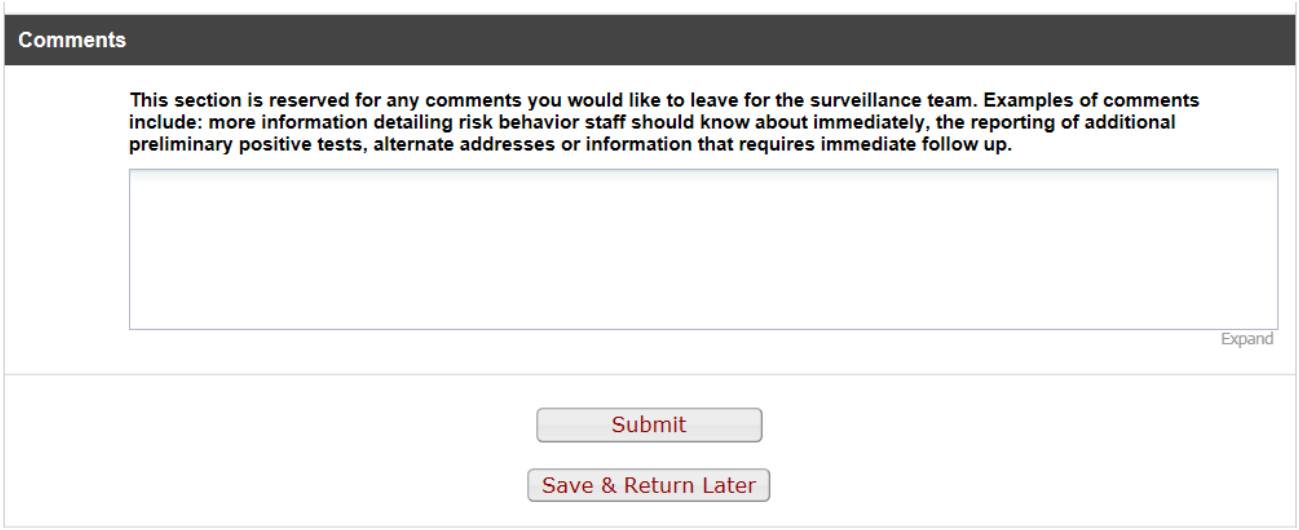
6) On Treatment
    - Please indicated whether the patient is on treatment or not

7) Please specify
    - If the patient is on treatment, please specify the regime.

8) Support Services
    - Please select all support services that may be necessary

9) Patient Concerns
    - Please select all applicable concerns.

Section 8: Comments



This section is reserved for any comments the provider or reporter would like to leave for the surveillance team. 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.

Appendix A- Case Report Form Quick Reference

Question	Description	Example
Section 1: Health Provider Information		
Reporting Facility Name	The full name of the facility that ran tests for and diagnosed HIV status.	Wellness Clinic of DC
Other Reporting Facility Name	Name of reporting facility if not included in the dropdown menu	HIV Specialists of DC
Date Form Completed	The date the form is being completed. This date should be filled even if it is sent at a later time.	05/10/2018
Person Completing Form	The person completing the physical form.	Dr. John Smith
Phone	The 10 digit telephone number to reach the person completing the form.	202-222-2222
Fax	The facsimile number to reach the facility reporting the case	202-222-2222
Program	The program under which the test was conducted	CTR
Service Type	Type of service provided to the patient	Outpatient
Street Address	The street address of the facility completing the form.	1000 Main Street NW
State	The state of the facility completing the form.	DC
City	The city of the facility completing the form.	Washington
County	The county of the facility completing the form.	Arlington County
Ward	The ward of the facility completing the form.	4
Country	The country of the facility completing the form.	USA
Zip Code	The zip code of the facility completing the form.	20002
Section 2: Patient 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.	29221
Social Security Number	The entire or partial social security number of the patient.	987-65-1234
Medical Record Number	The number associated with the patient's record.	RN54321
Sex assigned at birth	Assigned sex at the time of birth.	Female or Male.
If female, pregnant?	Female patients currently pregnant.	No.
If pregnant, weeks?	Gestational weeks	26
Current Gender Identity:	Male: Female: Transgender Female: Transgender Male: Additional Gender Identity:	Male
please, specify:	Specified gender identity, if Additional Gender Identity is selected.	Gender Neutral

Ethnicity	Hispanic/Latino Hot Hispanic/Latino Unknown	Hispanic
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. **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	White
Additional 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. **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,	Black

	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	
Section 3: 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/.	1000 Main Street NW Washington, DC 20002
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	The 10 digit telephone number to reach the patient.	202-222-2222
City	The city where the patient resides.	Washington
Ward	The ward of the patient.	4
County	The county of the patient.	Arlington County
Zip Code	The zip code where the patient resides.	21121
Home Phone Number	Home telephone number of the patient	202-222-2222

Mobile Phone Number	Mobile telephone number of the patient	202-222-2222
Preferred Phone Number	Patient's preferred contact telephone number	Home Number
Email Address	Patient's email address	John.Doe@dc.com
Was the patient notified that they may be contacted by DOH Disease Intervention Specialist (DIS)	The patient was notified and understands that they will be contacted by DOH partner services following the exam	Yes
Section 4: Risk History		
Sex with a male	The patient had sexual intercourse with a male.	Yes
Who is bisexual	The patient had sexual intercourse with a bisexual male.	No
Who is an injection drug user (IDU)	The patient had sexual intercourse with a male injection drug user.	No
Who is Human Immunodeficiency Virus (HIV) positive	The patient had sexual intercourse with a HIV positive male.	No
Who has received any of the following	The patient had sexual intercourse with a male who has received one of the following: transplant, transfusion, or has hemophilia/coagulation disorder.	Transplant
Sex with a female	The patient had sexual intercourse with a female.	Yes
Who is bisexual	The patient had sexual intercourse with a bisexual female.	No
Who is an injection drug user (IDU)	The patient had sexual intercourse with a female injection drug user.	No
Who is Human Immunodeficiency Virus (HIV) positive	The patient had sexual intercourse with a HIV positive female.	No
Who has received any of the following	The patient had sexual intercourse with a female who has received one of the following: transplant, transfusion, or has hemophilia/coagulation disorder.	Transfusion
Used injected non-prescription drugs?	The patient has or has not used injected non-prescription drugs.	No
Worked in a healthcare or clinical laboratory setting	The patient has worked in some healthcare or clinical laboratory setting.	Yes
Yes, specify occupation and setting:	The specific occupation of the patient	Administrative Worker
Setting	The healthcare or clinical laboratory setting	Mobile Treatment Van
Was the patient perinatally exposed to the disease being reported?	The patient was exposed to one or more of the diseases being reported prior to birth.	Yes
Section 5: Patient History		
Date of exam:	The date the patient was administered the exam.	05/10/2018
Reason for exam	The reason the patient entered your facility to undergo services.	Annual STD testing.
Was the patient on PrEP at the time of diagnosis?	The patient was prescribed Pre-exposure prophylaxis medication at the time of diagnosis.	Yes

Reporting Diseases	Chlamydia Gonorrhea Hepatitis B Hepatitis C HIV Syphilis Herpes 1 Herpes 2 Lymphogranuloma Venereum (LGV)	Gonorrhea Hepatitis C HIV
Section 6: Diagnosis and Treatment		
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
Date Treated	The date the patient received medication/treatment services.	5/16/2018
Treatment	The name of the treatment regimen prescribed to the patient.	Azithromycin 1g
Treatment Other	The name of the treatment regimen prescribed to the patient, if not previously indicated	
If referred for treatment, where?	The facility/provider the patient was referred to for treatment services	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	Cervix
Treatment	The name of the treatment regimen prescribed to the patient.	Ceftriaxone 250mg IM AND Azithromycin 1g
Treatment Other	The name of the treatment regimen prescribed to the patient, if not previously indicated	
Date Treated	The date the patient received medication/treatment services.	4/4/2014
If referred for treatment, where?	The facility/provider the patient was referred to for treatment services	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
Please select test type if result is positive:	**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
Please select another test type if result is positive:	**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	HBsAb
Test sample date	The date the sample was collected	05/10/2018
Please select another test type if result is positive:	**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	HBcAb Total
Test sample date	The date the sample was collected	05/10/2018
Please select another test type if result is positive:	**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	HBcAb IgM
Test sample date	The date the sample was collected	05/10/2018
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
Please select test type if result is positive:	**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

Please select another test type if result is positive:	**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 Screening Test
Test sample date	The date the sample was collected	05/10/2018
Please select another test type if result is positive:	**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 RIBA
Test sample date	The date the sample was collected	05/10/2018
Human Immunodeficiency Virus (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
If result is positive, please select test type:	**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
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
Test sample date	The date the sample was collected	5/10/2018
If result is positive, please select test type:	**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	HIV-1 RNA/DNA NAAT (Quantitative Viral Load)

	Amplification Test **HIV-1 RNA/DNA NAAT (Quantitative Viral Load)**: HIV-1 RNA/DNA Quantitative Nucleic Acid Amplification Test	
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
Test sample date	The date the sample was collected	5/10/2018
If result is positive, please select test type:	**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 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	1,000,000
Viral Load Test Units	If HIV-1 RNA/DNA NAAT (Quantitative Viral Load) is selected, list the test units	copies/ml
Test sample date	The date the sample was collected	5/10/2018
Was the client informed of HIV status?	The patient notification status of their HIV status.	Yes OR No
Was the client referred to HIV medical care?	The patient was or was not referred to HIV medical care.	Yes OR No
Reason the client not referred to HIV medical care?	If the patient was not linked to medical care after diagnoses list the reason.	Declined HIV Care.
If yes, where was the client referred	Name of facility where patient was referred to medical care.	Wellness Center of DC
Syphilis		
Stage	**Primary (chancre)** Characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance. **Secondary (rash, etc.)**	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 **Congential** 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 (non-viral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome 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	
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**	Ocular, Otic

	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	
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
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
CSF-VDRL Date:	The date the test was conducted	5/10/2018
CSF-VDRL Titer Results: 1:	The ratio results of the most recent CSF-VDRL (only the number following the 1:)	256
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.
Section 7: Pregnancy Reporting		
Is the patient engaged in obstetrical care?	The patient is pregnant and receiving obstetrical care	Yes
Expected Due Date	The expected delivery date of the baby	5/10/2018
Anticipated Delivery Hospital	The hospital the patient intends to deliver the baby	Washington Hospital Center
Has the patient been previously diagnosed with any of the following:	Hepatitis B Hepatitis C HIV Syphilis	Hepatitis B, HIV
Is the patient engaged in specialist care?	The patient is pregnant and engaged in specialist care	Yes

Is the patient currently on treatment for the above diagnoses?	The patient is currently on treatment for Hepatitis B	Yes
If yes, what medications?	The medications the patient is currently receiving for Hepatitis B	Bicillin 2.4mu IMx1, Atripla
Is the patient currently on treatment for the above diagnoses?	The patient is currently on treatment for Hepatitis C	Yes
If yes, what medications?	The medications the patient is currently receiving for Hepatitis C	Bicillin 2.4mu IMx1, Atripla
Is the patient currently on treatment for the above diagnoses?	The patient is currently on treatment HIV	Yes
If yes, what medications?	The medications the patient is currently receiving for HIV	Bicillin 2.4mu IMx1, Atripla
Is the patient currently on treatment for the above diagnoses?	The patient is currently on treatment for syphilis	Yes
If yes, what medications?	The medications the patient is currently receiving for syphilis	Bicillin 2.4mu IMx1, Atripla
Do you suspect problems with any of the following in your patient (check all that apply):	Medication Adherence Substance Abuse Mental Health Risk/History of falling out of care None	Medication Adherence, Mental Health
Are you concerned about any of the following in your patient (check all that apply):	Housing Nutrition/ Food Assistance Transportation None	Housing
Section 8: Comments		
This section is reserved for any comments you would like to leave for the surveillance team. 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.		Patient in treatment for mental health and substance abuse. Suspected domestic violence.