



Confidential HIV Case Report

State regulations* require reporting of all HIV infection diagnosed or treated in New Mexico.
Reports may be phoned to: (505) 476-1643 or securely faxed to (505) 476-3544, or mailed to:
New Mexico Department of Health
1190 St. Francis Dr., N 1350
Santa Fe, NM 87502-6110
Attention: Heidi Purcell

Person Completing Form: _____ Facility: _____ Phone: _____ Date: _____

DEMOGRAPHICS

Patient Name _____	Date of Birth _____	Phone _____
Current Address _____	City _____	County _____ State _____ Zip Code _____
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Gender of Transgender Persons: <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male	
Ethnicity: <input type="checkbox"/> Hisp. <input type="checkbox"/> Non Hisp	Race: <input type="checkbox"/> White <input type="checkbox"/> Native Am <input type="checkbox"/> African Am <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____ (Specify)	
Social Security # _____	Country of Birth _____	
Vital Status: <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Date of Death _____	Place of Death _____ (City, State)

EXPOSURE RISK

Sex with male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Sex with female: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Injected non-prescription drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.
Received clotting factor before diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, specify: <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Other _____		
Received transfusion of blood components before diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, specify year: First _____ Last _____		
Received tissue/organ transplant or artificial insemination before diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, specify: _____		
Worked in health-care or clinical laboratory setting before diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, specify: _____		
Ever been incarcerated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, received HIV diagnosis: <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After time of incarceration		
Sex w/sex worker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Sex for money or drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Sex w/multiple partners: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		
<u>HETEROSEXUAL RELATIONS WITH ANY OF THE FOLLOWING</u> (applies only to those reporting heterosexual contact):		
Injection drug user: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Bisexual male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		
Person with hemophilia/coagulation disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Transfusion recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		
Transplant recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. Person w/ documented HIV Infection or AIDS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		

LAB DATA

Date of First Western Blot _____	OI Diagnosis _____	Date _____
Hep C+? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Hep B+? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Syphilis +? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.
Residence at HIV Diagnosis: _____ (City, State, ZIP)	Residence at AIDS Diagnosis _____ (City, State, ZIP)	
Provider of Diagnosis _____	Facility of Diagnosis _____	
Current Physician _____	Lab where testing was done: _____	
CD4+ Results (first, most recent):	① _____ /uL, _____ % Date _____	② _____ /uL, _____ % Date _____
Viral Load Results (first, most recent):	① _____ copies/ml Date _____	② _____ copies/ml Date _____
Female Patients: Currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. If yes, Due Date: _____		