



# NOTIFICATION OF HIV INFECTION OR DEATH OF A PERSON WITH HIV INFECTION

OFFICE USE ONLY:

NSW HIV Number \_\_\_\_\_ Received Date \_\_\_\_\_

### PATIENT INFORMATION

Family name (first two letters only)    
 Given name (first two letters only)    
 Date of birth (DD/MM/YYYY): \_\_\_ / \_\_\_ / \_\_\_\_\_  
 Gender:  M  F  Transgender  
 Postcode of usual place of residence:       
 Patient/clinic record number: .....

### NOTIFYING DOCTOR DETAILS

Dr Name: .....  
 Dr Address: .....  
 .....  
 Ph: ..... Fax: .....  
 Email:.....  
 Date form sent to Dr \_\_\_ / \_\_\_ / \_\_\_\_\_

### LABORATORY INFORMATION

Lab Name:.....  
 Lab Number:.....  
 Lab Code:.....

#### 1. Date of specimen collection for this diagnosis of HIV

\_\_\_ / \_\_\_ / \_\_\_\_\_

#### 2. Results of tests performed for this diagnosis

##### a) Western blot

- Positive  Indeterminate group 4  
 Other Indeterminate  Negative  
 Not tested

##### b) Proviral DNA Positive Negative Not tested

##### c) p24 Antigen Positive Negative Not tested

#### 3. Laboratory evidence of newly acquired infection

##### a) Recent negative test (within 12 months) Yes No

Specify date \_\_\_ / \_\_\_ / \_\_\_\_\_

##### b) Evolving western blot\* Yes No

\* Typical evolution of HIV specific antibodies detected by Western blot in consecutive specimens consistent with primary HIV infection (incremental reactivity to gag, pol and envelope proteins of HIV-1)

#### 4. HIV virus type

- HIV-1  HIV-2  HIV-1 & HIV-2  Unknown

HIV subtype (if available) .....

### CD4 AND VIRAL LOAD INFORMATION

#### 5. Earliest CD4 count at the time of, or within 3 months of the date of this HIV diagnosis

CD4 count: ..... cells / $\mu$ L

Date \_\_\_ / \_\_\_ / \_\_\_\_\_

#### 6. Earliest viral load at the time of, or within 3 months of the date of this HIV diagnosis

Viral Load: ..... copies/mL

Date \_\_\_ / \_\_\_ / \_\_\_\_\_

### NOTIFICATION INFORMATION

#### 7. Other details of your patient

##### a) Country of birth

- Australia  Other (specify) .....

##### b) If other, specify year of arrival in Australia

##### c) Is your patient of Aboriginal or Torres Strait Islander origin? If both Aboriginal and Torres Strait Islander, mark both yes boxes.

- No  Yes, Aboriginal  Yes, Torres Strait Islander

##### d) What language does your patient mostly speak at home?

- English  Other (specify) .....

#### 8. Has your patient engaged in any sex work in the last 12 months? No Yes Unknown

#### 9. Has your patient ever had a previous HIV test?

- No previous tests  Unknown testing history

- Yes (specify date of results)

Most recent **negative** test: \_\_\_ / \_\_\_ / \_\_\_\_\_

Most recent **indeterminate** test: \_\_\_ / \_\_\_ / \_\_\_\_\_

First **positive** test: \_\_\_ / \_\_\_ / \_\_\_\_\_

#### 10. Place of first positive test

- NSW  Other State/Territory (specify) .....

- Overseas (specify) .....

#### 11. Source of information for previous test

- Patient/carer  Doctor  Laboratory

#### 12. Why was your patient tested for HIV antibody?

- Confirmation of a previous HIV diagnosis  
 Confirmation of a reactive HIV point of care test  
 Confirmation of a reactive HIV self-test  
 Patient was identified at risk via contact tracing  
 Partner with HIV infection  
 Reported recent risk behaviour  
 Baseline test prior to post exposure prophylaxis  
 Investigation of clinical symptoms suggestive of HIV  
 Screening –sexually transmissible infections  
 Screening –PrEP  
 Screening –immigration  
 Screening –antenatal  
 Other (specify) .....

➤ Please turn over

- 13. Who initiated the test for this HIV diagnosis?**  
 Doctor  Patient  Other (specify).....
- 14. What was your patient's clinical status at the time of specimen collection for this HIV diagnosis?**  
 Asymptomatic for HIV infection  
 Symptoms consistent with seroconversion illness  
 Other symptoms of HIV (specify).....  
 AIDS defining illness (specify).....  
 Deceased (post mortem diagnosis) → see **Q20 to 22**  
 Other (specify).....

- 15. Has your patient reported symptoms consistent with a seroconversion illness at the time of collection or prior to this HIV diagnosis?**  
 Yes  No  Unknown  
 If yes, specify date of onset of symptoms  
 \_\_\_ / \_\_\_ / \_\_\_\_\_
- 16. Has your patient ever taken pre-exposure prophylaxis?**  
 Yes  No  Unknown  
 If yes, specify the date of the most recent dose of PrEP  
 \_\_\_ / \_\_\_ / \_\_\_\_\_

**HIV RISK EXPOSURE**

- 17. Please indicate your patient's HIV exposure history:**
- Sexual exposure (tick one box ONLY)**  
 Sex with person of same sex  
 Sex with both sexes → see **Q19**  
 Sex only with persons of opposite sex → see **Q19**  
 Sexual exposure not known  
 No sexual contact
- Blood exposure (tick all appropriate boxes)**  
 Injecting drug use  
 Receipt of blood/tissue  
 Specify country.....  
 Specify year received
- Haemophilia/coagulation disorder
- Other exposure**  
 Mother-to-child transmission  
 Other potential sources of exposure (specify).....  
 .....
- Exposure to HIV is unclear/undetermined  
 If undetermined, are there potential exposures through medical procedures?  Yes  No  
 If yes, specify.....

- 18. Where was this HIV infection most likely to have been acquired?**  
 Australia  
 Overseas, specify country.....  
 Not known

- 19. Heterosexual sex was with a:**  
 (tick all appropriate boxes)  
 Man who has had sex with men  
 Injecting drug user  
 Recipient of blood/tissue  
 Person with haemophilia/coagulation disorder  
 Person with diagnosed HIV infection  
 Specify diagnosed partner's exposure.....  
 Person from a country other than Australia  
 Specify country.....
- AND**  
 Date of most recent sexual contact with this person  
 \_\_\_ / \_\_\_ / \_\_\_\_\_
- Heterosexual contact, not further specified

**PATIENT MANAGEMENT**

- 20. Please provide information about antiretroviral therapy for your patient. Antiretroviral therapy has been:**  
 Commenced  
 → Date \_\_\_ / \_\_\_ / \_\_\_\_\_  
 Deferred, reason:  
 Not clinically indicated, due to:  
  
 Patient declined, due to:  
  
 Treatment required for other condition, due to:  
  
 Other (specify):

**Note:** If you are no longer managing this patient for HIV, please provide the contact details of the doctor you have referred your patient to.

Name: .....

Contact details: .....

.....

**Contact tracing is the responsibility of the managing clinician. If you require assistance with contact tracing or any other aspect of the public health management of your patient, please contact your local Sexual Health Clinic. To find your closest appropriate sexual health service, call the NSW Sexual Health Infolink on 1800 451 624.**

**NOTIFICATION OF DEATH OF A PERSON WITH HIV INFECTION**

- 21. Date of death** \_\_\_ / \_\_\_ / \_\_\_\_\_
- 22. Source of information about this death**  
 Treating doctor  
 State/Territory Register of Deaths  
 Other (specify).....

- 23. What was the cause of death?**  
 AIDS related illness (specify).....  
 Accidental  Suicide  
 Drug overdose  Cardiovascular disease  
 Cancer  Liver disease  
 Not reported  Other (specify).....