CONFIDENTIAL

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 /μL

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

Patient name code: Family Name ☐☐ Given Name ☐☐ **Patient DOB:** __ __ / __ __ / __ __ __ __

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)*.....

Please return completed notification by post or secure fax to: HIV Surveillance Officer, Communicable Diseases Branch, NSW Ministry of Health, Locked Bag 2030 St Leonards NSW 1590. Fax: 02 9391 9189.
For further information phone: 02 9391 9195 or email: NSWH-HIV@health.nsw.gov.au