A working group of the National AIDS Strategy Committee

Human Immunodeficiency Virus (HIV) was added to the Schedule of the Infectious Disease Regulations (SI452/2011) in September 2011. This document was drafted by a working group of the National AIDS Strategy Committee (NASC) to provide information, to healthcare professionals who have a role in the diagnosis and care of persons living with HIV, on the notification process.
Committee
A working group of the National AIDS Strategy Committee

Title
HIV Notification – Information for professionals

Document purpose
Information for Irish Healthcare professionals regarding the statutory notification of HIV infection

Intended audience
All healthcare professionals who have a role in the diagnosis and care of persons living with HIV

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Table of Contents

Introduction .............................................................................................................................................. 4

Background ............................................................................................................................................... 4

Policy and coordination of the HIV response in Ireland ................................................................. 4

Data and information ............................................................................................................................. 4

Case based reporting of HIV in Ireland ............................................................................................... 4

The legislation .......................................................................................................................................... 5

The notification process ......................................................................................................................... 5

Confidential Computerised Infectious Disease Reporting (CIDR) ..................................................... 6

How should HIV be notified .................................................................................................................. 6

The laboratory and CIDR ....................................................................................................................... 6

The GP/clinician and the (paper) surveillance form ........................................................................... 7

What to notify .......................................................................................................................................... 8

When should HIV be notified ............................................................................................................... 9

Roles and responsibilities ..................................................................................................................... 9

What is the role of the clinician? ........................................................................................................... 9

What is the role of the GP? ................................................................................................................... 10

What is the role of Community testing services? .............................................................................. 11

What is the role of the NVRL? ............................................................................................................. 11

What is the role of the laboratory? ....................................................................................................... 11

What is the role of the Medical Officer of Health (MOH) and Department of Public Health? ...... 11

What is the role of the HPSC? ............................................................................................................. 12

What is the role of CIDR Users? .......................................................................................................... 13

Confidentiality and data protection ..................................................................................................... 13

Appendix A: Case definition; Human immunodeficiency virus infection ........................................ 14

Appendix B: Notification Dataset ....................................................................................................... 15

Appendix C: Supplementary questions for HIV (paper form) .......................................................... 17

Appendix D: CMO Circular Letter to Dr. Kevin Kelleher, HSE. 2011 .............................................. 18
Introduction

Human Immunodeficiency Virus (HIV) is now listed in the schedule of infectious diseases\(^1\). As a result, all newly confirmed diagnoses of HIV must be notified by clinicians and clinical directors of laboratories. Please note that statutory obligations apply only to a confirmed diagnoses, unconfirmed cases or those that do not meet the case definition should not be notified. Also, HIV diagnoses confirmed prior to January 2012 should not be notified.

The purpose of this document is to provide information on the notification process of newly confirmed diagnoses of HIV in Ireland. The document was drafted by a working group of the National AIDS Strategy Committee (NASC).

Background

Policy and coordination of the HIV response in Ireland

The national response to the global HIV/AIDS epidemic has evolved over the last three decades. The Department of Health (DOH) coordinated efforts, including the collection of data, during the 1980’s. In 1991, the Department established the National AIDS Strategy Committee (NASC). The committee advises the Minister on matters relating to; the Care and management of persons living with HIV, Education and Prevention of HIV, Surveillance and measures to avoid discrimination and stigmatisation of those living with HIV. NASC and its sub-committees have provided advice and guidance to the minister over the last two decades.

Data and information

Information regarding the first reported cases of HIV were gathered and collected by the DOH in 1982. The Department held responsibility for data collection and reporting until 1999. When the National Disease Surveillance Centre (NDSC) was established in 1998, NASC recommended that the newly established centre should assume responsibility for the surveillance of HIV in Ireland. Therefore, in 2000, the NDSC, now known as the Health Service Executive’s Health Protection Surveillance Centre (HPSC) assumed responsibility for managing HIV case based reporting and on behalf of NASC, developed an annual survey of Antenatal HIV screening in Ireland.

Case based reporting of HIV in Ireland

Prior to SI 452 of 2011, case based information on new HIV diagnoses was reported on a voluntary basis. Clinicians and GPs across the country reported newly confirmed diagnoses of HIV and AIDS to their respective Departments of Public Health. The information was then collated by the HPSC for analysis and national reporting.

The system of case based surveillance as devised and agreed by the NASC in the late 1990’s was appropriate and typical of its time. However, with improvement in diagnostic and therapeutic technologies the need for information has grown considerably. In effect, the system of reporting and surveillance of incident cases of HIV was no longer fit for purpose. Therefore after much deliberation, in October 2010, NASC made a recommendation to the Minister, that HIV should be added to the list of scheduled Infectious Diseases.

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The legislation
The Infectious Disease Regulations were amended by Statutory Instrument in September 2011. In making its recommendations, the membership of NASC expressed the desire and firmly insisted that the protection of patient privacy and confidentiality were of fundamental importance and must be safeguarded at all times. The membership was presented with developments in ID surveillance and how information technology could both protect patient privacy and enable person based surveillance of infectious diseases. The HPSC outlined the confidential Computerised Infectious Disease Reporting (CIDR) system. The membership of NASC made their recommendations for legislative change on the understanding that CIDR would be used for person based surveillance of HIV in Ireland. The HPSC gave a commitment to comply with these recommendations.

Therefore, the diseases and pathogens specified in the Schedule of Infectious Disease Regulations were amended in September 2011 (SI 452/2011). The revised schedule now includes Human Immunodeficiency Virus (HIV). As a consequence, all clinicians and clinical directors of laboratories have a statutory obligation to notify all new diagnoses of HIV.

The notification process
From the perspective of a GP or clinician who may wish to report, the process presently works in a manner similar to the voluntary case based system as established in 2003. If you are already familiar with case-based reporting, you will notice little or no change. As specified in the case definition for HIV, a HIV positive test must be confirmed by a second test. When a diagnosis is confirmed the National Virus Reference Laboratory (NVRL) issues a paper form for the collection of clinical, laboratory and epidemiological information relevant to the case. Completion of the form and providing the information requested, enables the clinician to fulfil his/her statutory obligation and no further action is required. Please note, there is an important distinction to be made between HIV testing or screening and statutory obligations to notify apply only to the diagnosis of new infections. It is also important to note that routine screening for HIV may be preformed anonymously.

The clinical notification process is initiated by the NVRL. Therefore it is not necessary for GPs or clinicians to provide information unless they are prompted to do so.

For a clinical directory of a laboratory, the process works through the confidential Computerised Infectious Disease Reporting (CIDR) system. The CIDR business process for notification of HIV is exactly the same as it is for all other ID notifications on CIDR. Therefore, once the test result is authorised, the clinical director of the laboratory will have discharged their statutory obligation.

This document outlines and explains in more detail the notification process as it applies to HIV. For general and background information on statutory notification, please refer to the Health Protection Surveillance Centre’s (HPSC) web-site. For information on HIV testing and other matters relating to HIV you may wish to refer to the links below.

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2 [http://www.hpsc.ie/hpsc/NotifiableDiseases](http://www.hpsc.ie/hpsc/NotifiableDiseases)
Confidential Computerised Infectious Disease Reporting (CIDR)

CIDR is a web-based electronic reporting system that can only be accessed through the Government VPN. CIDR is fully compliant with the Data Protection Acts (1988, 2003), Infectious Disease Regulations and is ISO27001 accredited. CIDR offers a safe and secure mechanism for notifying cases of infectious diseases, including HIV. A notification is a clinical or laboratory record and contains identifiable patient information; the dataset is presented in Appendix B. The dataset as outlined is standardised for all infectious diseases. Additional data may be specified from time to time. For HIV, the data items are outlined in Appendix C.

How should HIV be notified

The following outlines the processes that need to be adopted by those who notify infectious diseases under regulation, namely; laboratory directors and clinicians.

The laboratory and CIDR

The reporting of laboratory confirmed cases of HIV should only be managed through the confidential Computerised Infectious Disease Reporting (CIDR) system5. Figure 1 outlines the flow of information from the point of specimen collection to the reporting of HIV events by the HPSC. When a new diagnosis is confirmed by the National Virus Reference Laboratory (NVRL), the result will be entered into CIDR. This is consistent with CIDR business rules for the notification of all infectious diseases on CIDR. When the information is received by the source laboratory, the clinical director has the option to “authorise” the result and thus “notify” the Medical Officer of Health thus fulfilling his or her statutory obligation.

http://www.hse.ie/eng/services/Find_a_Service/Sexualhealth/Gay_Men’s_Health_Service/STI_Clinics,
www.yoursexualhealth.ie

5 http://www.hpsc.ie/hpsc/CIDR/
As mentioned above, figure 1 outlines the flow of information from the point of specimen collection to the reporting of HIV events by the HPSC. The key point for the clinician to note is that laboratory notification takes place through CIDR, and clinical data are collected on a paper form. To view the current form and data set please visit the HPSC website.

The clinical notification process is initiated by the NVRL. Therefore it is not necessary for GPs or clinicians to provide information unless they are prompted to do so. Once a new diagnosis is confirmed, the NVRL will send the result and a paper form to the clinician that requested the confirmatory HIV test. In most instances, the confirmatory test is requested by a consultant in Infectious Disease (ID) or Genitourinary Medicine (GUM). Therefore the majority of forms are directed to ID and GUM clinics. But there may be exceptions. Where exceptions are likely to arise, it may be helpful to agree, arrangements for case confirmation and management of surveillance forms at local/regional level. The arrangements should involve relevant Healthcare professionals including Departments of Public Health and should be consistent with the roles and responsibilities outlined.

below. If a clinician has concerns about the notification of a particular event, they are advised to discuss the matter with their laboratory and Department of Public Health.

When completing the paper form it is important to note that the paper form will never seek to acquire patient identifiers. Patient identifiers are entered into CIDR where they can be protected. In general patient identifiers are provided by the laboratory however on occasion, it may be necessary for the Medical Officer of Health (MOH) or an individual so nominated from the Department of Public Health to act on their behalf, to contact the clinician for confirmation and clarification of information, including patient identifiers. The role and responsibilities of MOH and clinician are outlined below.

**What to notify**

HIV infections diagnosed on or after January 1\(^{st}\), 2012 should be notified to the Department Public Health. The case definition stipulates that, a positive screening test must be confirmed by testing a second sample of blood. This is to ensure the provenance of the sample. In Ireland, the National Virus Reference Laboratory (NVRL) undertakes all HIV confirmatory testing and requires two positive results on two separate samples. If the provenance of the sample cannot be confirmed, the case cannot be notified. Figure 1 below outlines an algorithm for establishing a diagnosis and subsequent notification.

**Figure 2 Notification process**

<table>
<thead>
<tr>
<th>HIV Test</th>
<th>If negative: Reassure and advise</th>
</tr>
</thead>
<tbody>
<tr>
<td>If positive</td>
<td></td>
</tr>
<tr>
<td>Confirmatory Test</td>
<td>If negative: Discuss the need for a repeat test with the NVRL</td>
</tr>
<tr>
<td>If positive, AND:</td>
<td></td>
</tr>
<tr>
<td>THEN:</td>
<td></td>
</tr>
</tbody>
</table>

HIV diagnosis confirmed after December 31st 2011

To complete the notification process once diagnosis is confirmed by NVRL and a laboratory event is created on CIDR, follow steps 1 and 2:

1. The clinical laboratory director of the “local” laboratory must “authorise” the CIDR event and make this available to Public Health
2. The NVRL will send a surveillance form to the clinician/GP. The form must be completed and returned to the local Department of Public Health
When should HIV be notified

Only HIV infections diagnosed since January 1st 2012 should be notified. Diagnoses made prior to this date are not part of this process. If you have questions regarding diagnoses prior to this date, please contact your Director of Public Health.

The notification of HIV is an important step in the prevention, care and control of HIV in Ireland. It is essential that all newly confirmed cases are notified in a timely manner. A timely manner for the reporting of clinical information on HIV is defined as; the end of each quarter. CIDR has the capacity to adapt and report at more frequent intervals therefore laboratories are expected to report events on a daily or weekly basis.

Timely notifications will ensure that surveillance and prevention activities are effective and that incidents and outbreaks are identified early and managed promptly.

Roles and responsibilities

What is the role of the clinician?
The treating specialist physician is responsible for managing the clinical needs of their patient. The treating specialist physician will offer infection control advice and is also responsible for managing contact tracing. It is acknowledged that such services are not universally available; however, the treating specialist physician has a duty of care to ensure that appropriate action has been taken. The specialist physician will undertake enhanced surveillance and if this is not possible he/she will ensure that the process is facilitated.

The clinic and the treating specialist physician are responsible for diagnosis, treatment, care and management of the case. The specialist physician also has a duty to act on behalf of the Medical Officer of Health (MOH) and the Department of Public Health to ensure that reasonable effort is made to prevent the onward transmission of infection (DOHC November 2001). In order to do so effectively, the patient must have timely access to effective treatment and their sexual contacts informed of their possible exposure. Contact tracing is a complex and skilful activity. It is a vital intervention and should be undertaken by a trained health advisor or by a member of staff who is appropriately trained to undertake partner notification and contact tracing. Health advisors have a central role in gathering enhanced surveillance data.

Effective treatment and contact tracing is made all the more complicated by the stigmatisation and discrimination that surrounds HIV and that is experienced by people living with HIV. When working with patients who have been diagnosed with HIV it is critical to consider the impact that this

7 Contact tracing may also be known as Partner Notification, it is defined as: “...the process of contacting the sexual partners of an individual with a sexually transmitted infection including HIV, and advising them that they have been exposed to an infection. By this means, people who are at high risk of STI/HIV, many of whom are unaware that they have been exposed, are contacted and encouraged to attend for counselling, testing and other prevention and treatment services.” (WHO 1999).
stigmatisation can have. Additional challenges around disclosure, confidentiality and support structures may arise for some patients due to their sexual orientation. Therefore, managing patients with sensitivity and taking care to address their fears which are heightened due to stigma, and issues relating to confidentiality, are central elements to effective contact tracing and secondary prevention.

The diagnosing clinician and clinical laboratory director have a duty to notify Public Health with details of the test. The clinician should ensure that they balance their Public Health duties with a positive attitude towards HIV testing.

The CIDR laboratory record and the supplementary clinical dataset must be complete. The NVRL will arrange for a surveillance form to be sent to the specialist physician who requested the confirmatory HIV test. If the clinician is not the treating physician, on receipt of the form, they should redirect it to the treating physician for completion. If a form is redirected, Public Health should be informed. Alternatively, the form may be directed to the Department of Public Health for follow-up and action.

These are complex clinical and administrative undertakings and although accountability rests with the specialist physician who establishes the diagnosis, he/she should ensure that appropriate protocols and governance arrangements are put in place that will enable them to fulfil their obligation. The specialist physician should be able to provide the patient with copy of the clinic or practice confidentiality statement.

**What is the role of the GP?**

General Practitioners have a duty to offer their patients a HIV test when it is clinically indicated. GPs should ensure that they are familiar with local arrangements and care pathways for the diagnosis and management of HIV before a sample is collected. This is important information to share with patients.

When a sample tests positive, the NVRL will issue a result and recommend the taking of a second sample in order to confirm the diagnosis. In many instances, the GP will refer the patient on to an expert at this point. In this situation, the GP is not required to take any further action regarding notification, and they will not receive an enhanced surveillance form for completion.

If however the clinical or social needs of the patient are such that the GP needs to initiate a confirmatory test, when the diagnosis is confirmed, he/she will receive an enhanced surveillance form for completion. In this situation, given that the GP will not have all the necessary information to complete the form, he/she should ensure that the form is forwarded on to the relevant ID or GU physician providing care for the patient. Alternatively, the GP may send the form to the Department of Public Health. The Department of Public Health must be informed of actions taken on receipt of the form, in so doing the GP will have fulfilled his/her statutory obligation. The Department of Public Health working closely with the GP will liaise with the relevant specialist physician to follow-up on the completion of the form.
What is the role of Community testing services?
HIV testing takes place in a variety of settings. Testing in non-clinical settings, in the majority of instances will take the form of a HIV screening test. An individual that is screen-test positive, is not confirmed until a second sample is taken and tested. Therefore, the patient should be informed of the need for further testing and promptly referred on to a specialist centre. There is no obligation to notify the Department of Public Health of individuals who have a positive screen test result. Individuals and organisations that offer HIV testing have a duty of care to ensure that patients are aware of the test result and can facilitate prompt access to appropriate services when the need for such arises.

What is the role of the NVRL?
The National Virus Reference Laboratory (NVRL) may act as a local laboratory or as a reference laboratory. All HIV confirmatory testing takes place at the NVRL. Only HIV diagnoses confirmed on or after January 1st 2012 will be notified through CIDR. The NVRL must be satisfied with the provenance of the sample before a diagnosis can be confirmed i.e. two separate positive test results. Once a case is confirmed, the NVRL will create a new laboratory record on CIDR. When the NVRL acts as a local laboratory, the laboratory record is authorised by the NVRL and the information is directly available to Public Health within CIDR. When the NVRL acts as a reference laboratory, the laboratory record will need authorisation by the local referring laboratory before the information can be accessed by the Department of Public Health.

In order to capture supplementary clinical data, the NVRL will send a paper form to the clinician who requested the confirmatory test.

What is the role of the laboratory?
The local laboratory arranges for on-site HIV testing or for transportation to another laboratory where the test will be performed. Laboratory procedures will be consistent with national and international best practice and subject to quality assurance accreditation.

The laboratory director has a duty to notify the Department of Public Health of newly confirmed cases of HIV. When a case is confirmed by the NVRL, the clinical laboratory director will review the details and authorise the laboratory record on CIDR³.

Once the CIDR laboratory notification dataset is received in full, the clinical laboratory director will have fulfilled their statutory obligation.

What is the role of the Medical Officer of Health (MOH) and Department of Public Health?
The Medical Officer of Health and the Department of Public Health are responsible for the surveillance, prevention and control of all infectious diseases including HIV. Collectively, the Department of Public Health has a duty to prevent secondary spread of infection by advising on risk

³ CIDR will be the only mechanism used for sharing patient identifiers in the notification process and for completing the enhanced surveillance dataset
reduction measures and the protection of contacts. The Department of Public Health also have a duty to carry out enhanced surveillance of cases in order to provide epidemiological information which is designed to inform public health action, identify the likely source of infection and inform health service planning.

It is important to note that Departments of Public Health do not have detention powers. Article 8 of ID regulations 1981, as amended by SI No. 707 of 2003, states;

\[ All \ the \ infectious \ diseases \ listed \ in \ the \ Schedule \ to \ these \ Regulations, \ except: \ acute \ anterior \ poliomyelitis, \ cholera, \ diphtheria, \ influenza \ where \ it \ is \ influenza \ of \ a \ new \ or \ re-emergent \ subtype, \ paratyphoid, \ plague, \ severe \ acute \ respiratory \ syndrome \ (SARS), \ smallpox, \ tuberculosis, \ typhoid, \ typhus \ and \ viral \ haemorrhagic \ diseases (Lassa \ fever, \ Marburg, \ Ebola, \ Crimean-Congo) \ are \ excluded \ from \ application \ of \ Section \ 38 \ of \ the \ Health \ Act \ 1947 \ as \ amended \ by \ Section \ 35 \ of \ the \ Health \ Act \ 1953. \]

The Department of Public Health will fulfil their role by working with specialist physicians and clinical laboratory directors to ensure that CIDR records are completed in a timely manner and to ensure that the information is accurate. If records are incomplete, the Department of Public Health will contact the notifier and/or laboratory to ascertain additional information. The Department of Public Health will work in partnership with the treating specialist physician without making direct contact with an individual case. As is standard Public Health practice in the management of all infectious disease notifications, identifiable data are not shared with third parties.

**In the unlikely event that it becomes necessary for the Department of Public Health to establish contact with an individual patient or their contact; any subsequent intervention and action will be in partnership with the treating clinician.**

If an event merits the direct involvement of Public Health, the patient or their legal guardian will be consulted. Expressed consent will be sought and reasonable effort will be made to ensure that appropriate consultation takes place. However, the matter of consent does not preclude the involvement of Public Health. If consent is not forthcoming, the patient will be informed and a full explanation will be provided by the clinician or health advisor outlining why a particular course of action has been chosen.

Public Health will report to the HPSC on a weekly basis. Public Health will seek to provide local and regional providers with epidemiological and statistical summaries of infectious Disease notifications.

**What is the role of the HPSC?**

It is important to note that the HPSC do not have access to identifiable patient information when compiling epidemiological reports.

The HPSC will compile weekly and quarterly report of new diagnoses. Detailed epidemiological reports will be produced annually. The information will be reported annually to ECDC through The European Surveillance System (TESSY). The information will also be used to meet other international
reporting requirements to organisations such as WHO and UNAIDS. The HPSC will work with and support CIDR users. Reporting tools and queries will be developed to help users to provide timely information on local and regional epidemiological trends. The reporting tools will also support management of data quality.

**What is the role of CIDR Users?**

Access to confidential patient information on CIDR is restricted to named individuals and the Medical Officer of Health (as defined by paragraph 4 of Schedule 5 of the Health Act 2004) or other named individuals\(^\text{10}\) in the relevant Health Service Executive Area.

Individuals duly assigned will manage the notification process in accordance with the terms of the Infectious Disease Regulations 1981 and the relevant amending Statutory Instruments. Individuals managing the data will have certification to indicate that they have been trained in the use of CIDR. They will also certify that they are compliant with the Data Protection Act of 1988 and its amendments of 2003.

**Confidentiality and data protection**

All healthcare professionals, particularly those who process confidential patient information should be familiar with the recommendations and guidance considered in the documents referenced below:

- Health Information and Quality Authority (2011). *What you should know about Information Governance: A guide for health and social care staff*. Dublin, HIQA.

\(^{10}\) When the MOH is on leave, a formal ‘deputy’ may be nominated. A SPHM so appointed, has an ‘assigned’ MOH function.
Appendix A: Case definition; Human immunodeficiency virus infection

Clinical criteria
Not relevant for surveillance purposes

Laboratory criteria

Adults, adolescents and children aged ≥ 18 months

At least one of the following three:
- Positive result of a HIV screening antibody test or a combined screening test (HIV antibody and HIV p24 antigen) confirmed by a more specific antibody test (e.g. Western blot)
- Positive result of 2 EIA antibody test confirmed by a positive result of a further EIA test
- Positive results on two separate specimens from at least one of the following three:
  - Detection of HIV nucleic acid (HIV-RNA, HIV-DNA);
  - Demonstration of HIV by HIV p24 antigen test, including neutralisation assay;
  - Isolation of HIV.

Children aged < 18 months

Positive results on two separate specimens (excluding cord blood) from at least one of the following three:
- Isolation of HIV;
- Detection of HIV nucleic acid (HIV-RNA, HIV-DNA);
- Demonstration of HIV by HIV p24 antigen test, including neutralisation assay in a child ≥1 month of age.

Epidemiological criteria
NA

Case classification

A. Possible case
   NA

B. Probable case
   NA

C. Confirmed case
   Any person meeting the laboratory criteria for HIV infection
Appendix B: Notification Dataset

Event details
- Disease
- Organism
- Case classification
- Health Board
- County
- CCA
- Interpreted Overall Lab Result

Patient Record
- Title, First name, Surname, Former Surname
- Date of birth
- Gender
- Ethnicity
- Country of birth
- Occupation
- Employment status
- Marital status
- Address line 1, Address line 2, Suburb, Town, Postcode,
- County, CCA, Health Board of residence
- Phone, mobile, email

Clinical Record
- Date of notification
- Case classification
- Patient age
- Country of infection
- County, CCA, Health Board
- Comments
- Patient type
- Hospital
- Hospital Number
- Date of admission
- Clinical description
- Diagnosis date
- Onset date
- Outcome
- Cause of death
- Date of death
- Notifying clinician
Laboratory Record
- Date of notification
- Specimen ID, Reference Lab Specimen ID
- Specimen type, Specimen site, Specimen site qualifier
- Specimen collected date, Specimen received date, Reference Lab Specimen received date
- Reported date
- Organism
- Lab test, Lab test result
- Patient title, First name, Surname, Former Surname
- Date of birth
- Patient age (if date of birth not known)
- Gender
- Address line 1, Address line 2, Suburb, Town, Postcode
- County, CCA, Health Board of residence
- Reference Lab Comments
- Source Lab Comments
- Patient type
- Hospital, Hospital Ward
- Hospital Number
- Referring Clinician
- Notifying clinician
Appendix C: Supplementary questions for HIV (paper form)

- Region of origin
- Sexual orientation:
- Pregnant (at time of HIV diagnosis): Yes/No
- Gestational Age (Weeks):
- Reason for HIV test:
- If other reason for test:
- Probable route of transmission:
- If other, route of transmission:
- If IDU, duration of injecting drug use (years):
- If heterosexual, subcategory:
- If MTCT, Mother’s Risk Group:
- Timing of mothers diagnosis: before, during pregnancy, during labor or after birth
- ART for mother and/or baby: Yes/No
- ART given antenatally: Yes/No
- ART given intra-partum: Yes/No
- CD4 count at time of HIV diagnosis:
- CD4% at time of HIV diagnosis:
- Viral load at time of HIV diagnosis:
- HIV Type:
- Evidence of recent infection (within 3 months)
- Date of initial screening test by NVRL
- Previously tested positive for HIV:
- If previously positive, country of positive test:
- If previously positive, year of positive test:
- Previously tested negative for HIV:
- If previously negative, country of test:
- If previously negative, year of test:
- Co-infection with Syphilis: Yes/No
- Co-infection with Chlamydia trachomatis: Yes/No
- Co-infection with Gonorrhoea: Yes/No
- Co-infection with Hepatitis B: Yes/No
- Status of Hepatitis B infection i.e. acute/chronic
- Status of Hepatitis C infection i.e. acute/chronic
- Clinical Stage of HIV at time of diagnosis
- Date of AIDS diagnosis
- AIDS defining illness
- ART indicated: Yes/No
- ART initiated: Yes/No
- Date ART initiated: Yes/No
- Enhanced ART initiated: Yes/No
- Enhanced form completed by:
- Date enhanced form completed:
Appendix D: CMO Circular Letter to Dr. Kevin Kelleher, HSE. 2011

December 2011

Dr Kevin Kelleher
Assistant National Director
Health Service Executive
Second Floor
Mount Kennedy House
Henry Street
Limerick

Dear Dr Kelleher

I have become aware of varying practices in relation to the reporting, by medical practitioners, of notifiable infectious diseases to the Medical Officer of Health (MOH). In that context and in view of the recent amendment to the Infectious Disease Regulations, 1981, I wish to clarify the reporting requirements under the Regulations.

The Schedule to the Regulations which was amended in September 2011, added a number of infectious diseases e.g. Carbapenem-resistant enterobacteriaceae infection (invasive), Clostridium difficile infection, Human immunodeficiency virus infection, Lyme disease etc. The revised Schedule of notifiable diseases is attached for ease of reference.

To enable the MOH carry out his/her statutory responsibilities, the diseases listed in the Schedule are required to be notified by medical practitioners and clinical directors of diagnostic laboratories, to the MOH in the HSE. This obligation applies to all notifiable diseases including sexually transmitted infections. Refusal to comply with these notification requirements is contravening the Regulations.

The Data Protection Act allows the “fair obtaining” of personal data under an enactment such as the Infectious Diseases Regulations. The MOH requires personally identifiable information in order to control and prevent the onward transmission of infectious diseases. The provision of this information to a MOH under the Infectious Diseases Regulations, for these purposes does not contravene the responsibilities of medical practitioners or clinical directors of diagnostic laboratories under the Data Protection Legislation. The core CIDR dataset is outlined in the appendix of this document. This is a universal dataset and is applicable to all notifiable infectious diseases. A supplementary dataset for specific diseases which are under enhanced surveillance may also be required.

Tús Áite do Shábháilteacht Óthar Patient Safety First
A patient with a notifiable disease (suspected or confirmed), or a carrier of a notifiable disease, should be advised of the statutory obligation to provide certain details to a MOH under the Regulations.

I would appreciate if you would bring the content of this letter to the attention of all medical practitioners and clinical directors of diagnostic laboratories.

Yours sincerely

[Signature]

Dr. Tony Holohan
Chief Medical Officer

Ce Dr Darina O’Flanagan, HPSC