

HIV Surveillance Report Form

Note: If you have referred this patient to a HIV treatment centre, please indicate the doctor and hospital/clinic they have been referred to

A: NVRL Details

1. NVRL Laboratory Specimen ID 3. Reporting GP/Consultant
 2. Date of confirmatory test 4. Hospital/Clinic

B: Patient Details

5. DOB 6. Sex M ☐ F ☐ Unk ☐ 7. Irish county of residence
 8. Ethnicity ☐ White Irish ☐ Black African ☐ Asian Other
☐ White Irish Traveller ☐ Black Other ☐ Other/Mixed Ethnicity
☐ White Other ☐ Asian Chinese ☐ Unknown
 9. Country of Birth 9a. If born abroad, year of arrival in Ireland
 10. Probable country of infection
 11. Pregnant at time of HIV diagnosis? Yes ☐ No ☐ Unk ☐ 11b. If pregnant, gestational age (weeks)
 12. Reason for HIV test ☐ Symptomatic ☐ Antenatal ☐ Voluntary asylum seeker screening
☐ Known positive partner ☐ Blood donor ☐ Unknown
☐ Risky behaviour ☐ STI screen ☐ Other Please state

C: Probable Route of HIV Infection

13. Probable Route of HIV Infection (please tick one)
☐ **Men who have sex with men (MSM)**
☐ **Injecting Drug Use (IDU) (ever injected drugs)** If yes, duration of drug use (years)
☐ **Heterosexual contact – if yes, please choose subcategory**
☐ Originates from a country with a generalised HIV epidemic ☐ Sex with a haemophiliac/transfusion recipient
☐ Sex with a person from a country with a generalised HIV epidemic ☐ Sex with a bisexual male/MSM
☐ Sex with an IDU ☐ Sex with a person known to be HIV infected
☐ Infected through heterosexual transmission, no further information
☐ **Mother to Child Transmission (MTCT) – if yes, please choose subcategory**
☐ IDU ☐ Infected through heterosexual transmission, no further information
☐ From a country with a generalised HIV epidemic ☐ Other / undetermined
☐ Transfusion recipient
☐ **Other (if other, please specify)**
☐ **Unknown**

D: Laboratory Information (at time of this diagnosis in Ireland)

14. CD4 count at time of diagnosis (cells/microlitre) 14a. Date of CD4 test
 15. Viral load at time of diagnosis (copies/ml) 15a. Date of viral load

E: Testing History (prior to this diagnosis)

16. Previously diagnosed HIV positive abroad Yes ☐ No ☐ Unk ☐
 If yes 16a. Country of previous positive test
 16b. Year of previous positive test
 17. Previously tested negative for HIV Yes ☐ No ☐ Unk ☐
 If yes 17a. Month of negative test 17b. Year of negative test

F: Co-Infections

Is the patient known to be co-infected with:

- | | Yes | No | Unk | | Yes | No | Unk |
|----------------------------------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|--------------------------|
| 18. Early (infectious) Syphilis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. TB | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. <i>Chlamydia trachomatis</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Gonorrhoea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 23. Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, Acute ☐ Chronic ☐ Unk ☐
 If yes, Acute ☐ Chronic ☐ Unk ☐

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G. Treatment Information

24. When did the patient start Anti-retroviral therapy?

- ☐ ART started at this diagnosis, if yes, please state month and year started Month Year
☐ Patient previously on ART in another country, if yes please state month and year started Month Year
☐ ART not indicated

25. Has this person transferred their HIV care to Ireland from another country? Yes ☐ No ☐

26. Did the patient receive post exposure prophylaxis and/or pre-exposure prophylaxis in the 6 months prior to HIV diagnosis?

- ☐ No ☐ Yes- PEP and PREP
☐ Yes - PEP ☐ Unknown
☐ Yes - PREP

H. Clinical Stage and AIDS (at the time of this HIV diagnosis in Ireland)

27. Clinical presentation at time of this HIV diagnosis (please tick one)

- ☐ Acute, Seroconversion illness (please complete section I) ☐ AIDS defining (see questions 28-32)
☐ Asymptomatic ☐ Non-AIDS, not further specified
☐ Symptomatic, non-AIDS ☐ Unknown

28. If AIDS at time of this diagnosis, please give the date of AIDS diagnosis

If AIDS, please indicate at least one AIDS defining illness (see list on page 3)

29. AIDS defining illness 1 31. AIDS defining illness 3
 30. AIDS defining illness 2 32. AIDS defining illness 4

I: Deaths

33. Has the patient died Yes ☐ No ☐ Unk ☐If yes 33a. Date of Death If yes 33b. Cause of Death AIDS ☐ Non-AIDS ☐ Unk ☐

If the patient subsequently dies, please inform your local Department of Public Health

J: Form Completed By

41. Form completed by Block Capitals
 Signature
 Clinic/Service
42. Date completed

Comment: Please give relevant details not covered elsewhere

Please return this form in strictest medical confidence to the Director of Public Health in your local Department of Public Health.
 For who to notify, see <http://www.hpsc.ie/notifiablediseases/whotonotify/>

If the patient has been referred elsewhere for HIV care, please forward this form to the clinician they have been referred to.

Guidelines for completing the HIV Surveillance form

Please complete all relevant sections of this form and return in strictest medical confidence to the Director of Public Health in the Department of Public Health where the patient resides. For a list of who to notify, please see

<http://www.hpsc.ie/notifiablediseases/whotonotify/>

If the patient has been referred elsewhere for HIV care and you are unable to complete the form, **please forward this form to the clinician they have been referred to.**

Section A: NVRL details

This section will be completed by the National Virus Reference Laboratory at time of confirmatory HIV diagnosis. The NVRL laboratory ID will be used to as an identifier on the paper form

Section B: Patient details

Section C: Probable Route of HIV Infection

Reliable information about probable route of HIV infection and of the patient's exposure within that risk category is especially important. IDU should be ticked if the patient **ever** injected drugs. Heterosexual contact is used for cases for which heterosexual transmission is highly probable and do not fit into another category. It is important that the source of infection for heterosexual cases is provided.

Section D: Laboratory Information

CD4 count and Viral load should be provided at the time of this diagnosis

Section E: Testing History

This seeks where possible to define the period during which infection occurred.

Section F: Co-infections

This seeks to determine if the patient has any other co-infections at the time of HIV diagnosis

Section G: Treatment Information

This seeks to determine if the patient was on ART in another country, or is starting ART. Also, if the case was transferred from another country

Section H: Clinical Stage and AIDS

This information asked for in this section will be used to establish the stage of disease progression at which the HIV diagnosis has been made. In the case of an AIDS defining illness, at least one (and a maximum of four) AIDS defining illnesses should be stated. A full list of AIDS defining illnesses is shown in the table below.

Section I: Deaths

This section should be completed for all cases. If a patient subsequently dies, please inform your local Department of Public Health

Section J: Form completion details

List of AIDS Defining Illnesses

1. Bacterial infections, multiple or recurrent in a child under 13 years of age
2. Candidiasis of bronchi, trachea, or lungs
3. Candidiasis, oesophageal
4. Coccidioidomycosis, disseminated or extrapulmonary
5. Cryptococcosis, extrapulmonary
6. Cryptosporidiosis, intestinal with diarrhoea (>1 months duration)
7. Cytomegalovirus disease (other than liver, spleen, or nodes) in a patient over one month of age
8. Cytomegalovirus retinitis (with loss of vision)
9. Herpes simplex: chronic ulcer(s) (>1 months duration); or bronchitis, pneumonitis, or oesophagitis in a patient over one month of age
10. Histoplasmosis, disseminated or extrapulmonary
11. Isosporiasis, intestinal with diarrhoea (>1 months duration)
12. Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
13. Mycobacterium tuberculosis, pulmonary in an adult or an adolescent (aged 13 years or over)
14. Mycobacterium tuberculosis, extrapulmonary
15. Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
16. Pneumocystis carinii pneumonia
17. Pneumonia, recurrent in an adult or an adolescent (aged 13 years or over)
18. Progressive multifocal leukoencephalopathy
19. Salmonella (non typhoid) septicaemia, recurrent
20. Toxoplasmosis of brain in a patient over one month of age
21. Cervical cancer, invasive in an adult or an adolescent (aged 13 years or over)
22. Encephalopathy, HIV-related
23. Kaposi's sarcoma
24. Lymphoid interstitial pneumonia in a child under 13 years of age
25. Lymphoma, Burkitt's (or equivalent term)
26. Lymphoma, immunoblastic (or equivalent term)
27. Lymphoma, primary, of brain
28. Wasting syndrome due to HIV
30. Opportunistic infection(s), not specified
31. Lymphoma(s), not specified

Thank you very much for completing this form.

Further information on HIV surveillance can be obtained from www.hpsc.ie