5.6 Human Immunodeficiency Virus REPORTABLE

ETIOLOGY

- The human immunodeficiency virus (HIV) is a retrovirus.
- Two types have been identified: *type 1 (HIV-1*) and type 2 *(HIV-2).* These viruses are serologically, geographically and epidemiologically distinct. The transmissibility and pathogenicity of HIV-2 may be lower than HIV-1. This policy addresses HIV-1 only.
- HIV has been shown to be the causative agent of acquired immunodeficiency syndrome (AIDS).

CASE DEFINITIONS

Confirmed case

Adults, Adolescents and Children >18 months:

- detection of HIV antibody with confirmation (e.g. EIA screening with confirmation by Western blot or other confirmatory test)
  OR
- detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA)
  OR
- HIV p24 antigen with confirmation by neutralization assay
  OR
- isolation of HIV in culture

Children < 18 months (on two separate samples collected at different times)

- detection of HIV nucleic acid (e.g. DNA PCR or plasma RNA)
  OR
- HIV p24 antigen with confirmation by neutralization assay
  OR
- isolation of HIV in culture

Pediatric cases only (<15 years old)

- Bacterial infections (multiple or recurrent, excluding recurrent bacterial pneumonia) AND must have laboratory evidence of HIV infection
- Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (may be diagnosed presumptively if laboratory evidence of HIV infection is present).

CLINICAL FEATURES

- Infection with HIV results in the progressive destruction of cells (CD4+ T lymphocytes) that are crucial to the normal functioning of the immune system.
- The person with HIV infection may experience several stages:

    - Primary or acute HIV infection.
    - Chronic asymptomatic HIV infection.
    - Chronic symptomatic HIV infection.
- Persons with HIV infection develop immune suppression and consequently are at risk of developing a variety of clinical AIDS-defining conditions, including opportunistic infections and malignancies.

Adults

- Within seven to 10 days of infection with HIV up to 90% of persons develop a non-specific, self-limited illness known as the **acute retroviral phase**.
    - Symptoms may include fever malaise, rash headache, pharyngitis, anorexia, weight loss, lymphadenopathy and fatigue.
    - These symptoms usually resolve within two weeks.
    - This stage is often undiagnosed.
    - During this period of time individuals are to be considered highly infectious.
- Following the primary infection, patients may remain asymptomatic for years. Without treatment the average time to the development of an AIDS-defining illness is 8 to 15 years. With treatment the life expectancy of a HIV positive individual is comparable to a non-HIV positive individual.
- Clinical illness may include opportunistic infections such as Pneumocystis jiroveci pneumonia, disseminated Mycobacterium avium complex, and primary neurologicdisease (e.g. AIDS dementia) and malignancy (e.g. lymphoma, Kaposi sarcoma).
- Effective early treatment reduces the mortality related to HIV and progression to an AIDS diagnosis.

Table 1: Symptoms of HIV infection by stage of disease

Acute HIV Infection	**Chronic Symptomatic HIV**	**AIDS-defining Conditions (requires concurrent positive HIV serology)**
• Fever • Arthralgia • Myalgia • Rash • Lymphadenopathy • Sore throat • Fatigue • Headache • Oral ulcers and/or genital ulcers • >5 kg weight loss • Nausea, vomiting or	• Oral hairy leukoplakia • Unexplained fever (>2 weeks) • Fatigue or lethargy • Unexplained weight loss (>10% body weight) • Chronic diarrhea (>3 weeks) • Unexplained lymphadenopathy (usually generalized) • Cervical dysplasia	• Bacterial pneumonia, recurrent • Candidiasis (esophageal, bronchi, trachea or lungs) • Cervical cancer, invasive • Coccidioidomycosis (disseminated or extrapulmonary) • Cryptococcosis (extrapulmonary)

diarrhea	• Dyspnea and dry cough • Loss of vision • Recurrent or chronic mucocutaneous candidiasis (oral, esophageal, vaginal) • Dysphagia (esophageal candidiasis) • Red/purple nodular skin or mucosal lesions (Kaposi sarcoma) • Encephalopathy • Herpes zoster, especially if severe, multidermatomal or disseminated • Increased frequency or severity of mucocutaneous herpes simplex virus infection • Unexplained “anemia of chronic disease”	• Cryptosporidiosis (chronic intestinal) • Cytomegalovirus disease (other than liver, spleen, nodes) • Cytomegalovirus retinitis (with loss of vision) • Encephalopathy, HIV-related (dementia) • Herpes simplex virus (chronic ulcers or bronchitis, pneumonitis or esophagitis) • Isosporiasis, chronic intestinal • Kaposi sarcoma • Lymphoma (Burkitt, immunoblastic, primary in brain) • Mycobacterium avium complex or M. kansasii (disseminated or extrapulmonary) • Mycobacterium of other species (disseminated or extrapulmonary) • Mycobacterium tuberculosis (pulmonary, disseminated or extrapulmonary) • Pneumocystis jiroveci (formerly carinii) pneumonia • Progressive multifocal leukoencephalopathy • Salmonella septicemia, recurrent • Toxoplasmosis of brain • Wasting syndrome due to HIV

Source: Canadian Guidelines on Sexually Transmitted Disease, 2013

Children:

- HIV infection is most often asymptomatic among infants and children. The median time to disease progression of treated peri-natally infected children is believed to be similar to that of adults.
- Ten per cent to 20% of peri-natally infected children who are untreated will present with symptomatic disease within the first year of life. With treatment, disease progression is delayed.
- Prenatal care should include HIV testing to better identify those who are at risk. Mothers who are identified as HIV infected and receive appropriate treatment have an 80% chance of not transmitting the infection to their babies.
- Children and infants who do present with symptoms may have any of the following:
    - irritability, poor weight gain, developmental delay, recurrent respiratory problems, recurrent otitis or sinusitis, persistent rash, persistent thrush, persistent or recurrent lymphadenopathy, diarrhea or fever.

DIAGNOSIS

The diagnosis of HIV infection is based primarily on a positive serologic test.

For confirmation on laboratory specimens, contact the NL Public Health Laboratory at 709-777-6583 or visit their website:

http://publichealthlab.ca/service/hiv-abag-human-immunodeficiency-virus-iii-serology/

Laboratory Tests

Table 2: Testing algorithm for HIV

Reporting Name	Available separately	Always performed
HIV Screen	N/A	N/A
HIV-1/2 Antigen/antibody combo assay	NO	YES
HIV-1 WB (HIV-1 Western Blot)	NO	NO
HIV-2 WB (HIV-2 Western Blot)	NO	NO

Source: NL Public Health Laboratory

Notes:

- Serum/plasma screened for HIV p24 antigen and HIV 1/2 antibodies employing HIV antigen/antibody combo assay.

- Reactive specimens are confirmed by HIV 1 specific Western blot (ie: immunoblot, ImB).

Specimen Collection

Specimen Required

Serology: Suitable specimens are individual samples (human sera or EDTA/heparinized/citrated plasma) obtained by standard laboratory techniques.

Specimen Minimum Volume

0.6ml

Table 4: Transport Temperature

Specimen	Room temperature	Refrigerated	Frozen
Serum/plasma	YES*	YES**	YES***

Source: NL Public Health Laboratory

*The samples should not be stored for more than 3 days at room temperature.

**The samples should be stored for not more than 14 days at 2-8°C.

***For longer delay, freeze at -70°C and transport on dry ice.

Interpretation of Results

Table 3: Interpretation of results

Interpretation

HIV Ag/Ab	HIV Western Blot	Interpretation	Comments
Non-reactive	*N/A*	*Negative*	*If high risk and acute infection is suspected retest in 1 – 2 weeks.*
Reactive	*Non-reactive*	*Negative*	*If high risk or acute infection is suspected retest in 1 – 2 weeks.*

Reactive	*Indeterminate*	*Indeterminate*	*Repeat testing to detect seroconversion*
Reactive	*Reactive*	*Positive*	Confirmed case*

Source: NL Public Health Laboratory

*If a patient is found to be HIV-positive, a repeat blood collection and testing should be ordered to validate results.

Pediatric Considerations

HIV antibody testing cannot establish HIV infection in infants <18 months old due to persistent maternal anti-HIV antibodies in HIV-positive mothers. Confirmation of HIV infection in those <18 months old should be based on two positive virologic tests (HIV RNA/DNA PCR) obtained from separate blood samples. Definitive exclusion of HIV infection (in the absence of breastfeeding) should be based on at least two negative virologic tests (one at >1 month and one at >4 months of age).

EPIDEMIOLOGY

Occurrence

- The epidemic is a complex one as there are different rates of infection in specific at-risk populations.
- Men who have sex with men (MSM) still represent the largest number and proportion of positive HIV test reports. The second largest exposure category is heterosexual transmission followed by injection drug use (IDU).
- Rates of HIV infection in Canadian provincial and federal prisons appear to be much higher than in the general population.
- An estimated 30% of those infected are unaware of their HIV status.
- There has been a marked decline in the number of persons diagnosed with AIDS in Canada. The use of highly active antiretroviral therapy (HARRT) is the major factor responsible for this decline.

Reservoir

- Humans

Incubation

- Usually 1-3 months but can be variable. The time frame from infection to detectable antibodies can range from two to three weeks to six months.

Transmission

- Transmission of HIV is from person to person.

- Common modes include sexual contact and sharing of HIV-contaminated needles, syringes and other equipment for drug injection.
- The HIV virus is most commonly found in and transmitted through blood, body fluids containing blood and other fluids (i.e. semen, vaginal secretions and anal fluids) with a high viral load. The virus has been isolated from urine, salvia, tears, and bronchial secretions; however transmission from these fluids has not been reported.
- Concurrent sexually transmitted infection (STIs) especially ulcerative STI greatly facilitates the transmission and acquisition of HIV.
- Infection may be transmitted vertically from mother to child during pregnancy, delivery or through breastfeeding.
- Transmission of HIV through blood products and organ/tissue transplants is extremely rare in Canada since screening of donors was instituted in 1985.
- The current estimated risk of infection from blood and blood products is exceedingly low in Canada (approximately one per million units of blood).

Communicability

- Epidemiological evidence suggests that transmissibility begins early after the onset of HIV infection and extends throughout life.
- Infectiousness is highest during the initial infection, and rises with increasing immune deficiency.

CONTROL MEASURES

Management of Cases

Investigations

1. Determine the reason for the test (from the case or physician).
2. Assess potential risk factors for infection including:
    - Men having sex with men.
    - Sharing of needles or other drug paraphernalia e.g., straws, spoons for illicit/street drugs, pipes used for inhalation of illicit/street drugs,
    - Incarceration
    - Receipt of blood/tissue/organ between 1978 and 1985.
    - Receipt of blood/tissue/organ at any time in a developing country.
    - Skin piercing procedures e.g., tattooing, body piercing, acupuncture.
    - Workplace exposure.
    - Recent invasive medical or dental procedures.
    - History of medical procedure in an HIV-endemic country.
    - Sex with partners with identified risk factors.
    - Individuals with symptoms and signs of HIV infection.
    - Individuals with illness associated with immunocompromise or a diagnosis of tuberculosis.
3. Assess sexual relationships and high-risk sexual behaviors including:

- Alcohol and non-injection drug use prior to sexual activity.
- Participation in unprotected anal, vaginal and/or oral sex outside of a mutually monogamous relationship.
- Multiple sex partners (including sex trade workers).
- Sex with partners from a HIV-endemic country or with partners with any of the above risk factors.

4. Ascertain status of co-infection with other sexually transmitted infections and bloodborne infections (STBBIs).
5. If female, determine pregnancy status.

Follow up of Cases

- **Recommendations should be made in collaboration with a physician experienced in HIV/AIDS care and treatment.**
- Public health personnel should contact the physician within two working days of receipt of positive test result to determine who will initiate completion of the *HIV/AIDS Case Report* and to make them aware of the need for:
    - public health follow-up including client education
    - follow-up of contacts
    - obtaining additional epidemiological information
    - assessing the risks associated with other STIs, hepatitis B and hepatitis C.
- Positive pregnant women should be advised of evidence regarding antiretroviral drugs in preventing perinatal transmission and should receive antiretroviral therapy prenatally (typically at the start of the second trimester) and during labor and delivery.
- Ensure physician aware of referral process to Provincial HIV/Infectious Diseases Clinic
- Encourage regular follow-up with a physician experienced in HIV/AIDS care and treatment.
- Encourage and support people who are HIV positive to take the medications
- prescribed for them.

Management of Contacts

Definition of Contact

- A person who has had sex, reused injecting equipment or has had some relevant high risk exposure to the case.

Notification

- It is a public health responsibility to ensure that partner notification and follow-up takes place. All HIV-positive individuals are assumed to be infectious and capable of transmitting the virus through exchange of blood and body fluids. They must, therefore, be interviewed to identify and disclose names of their sexual and needle-sharing partners.
- Partner notification and follow-up of drug sharing and sexual partners must be undertaken on all reported cases of HIV infection and AIDS.

- In order to protect the identity of the source, the source identity, the date, and the nature of the exposure should **NOT** be revealed to the contact.
- Tracing of partners should be based on the estimated duration of infection. If the date of seroconversion is known, all partners in the **6 months** prior to the positive testing should be identified.
- Trace-back period for HIV is variable and depends on a number of factors, including time frame when risk behavior began, last known negative test if available, epi link with known case.
- All identifiable partners should be notified within **1 month** of the case disclosing contact information.
- It is recommended to meet with the contact in person. Pre- and post- test counselling should be offered to all contacts.
- Collaboration between the primary care physician, public health personnel and the infectious disease physician is essential.
- Public health personnel should be available to assist physicians with partner notification and help with appropriate referral for clinical evaluation, testing, treatment, and health education.
- Both the physician and public health personnel conducting contact tracing, should always provide partners with information that includes:
    - Modes of transmission.
    - Disease process.
    - How to modify risky behaviors.
    - Contact information of support agencies and testing clinics.
- All partners should be encouraged to be tested for HIV and given specific details on where to be tested, and how it will be reported if positive.
- Pregnant female contacts:
    - Should be given priority for follow-up.
    - Should have additional testing during pregnancy and/or prior to delivery based on continued risk behavior.
    - Should have close follow up. If the woman does not return for retesting, public health personnel and/or the primary care physician should make attempts to contact her and provide additional information and/or support.
    - In addition to standard HIV testing, an HIV specialist should be consulted regarding additional tests (e.g., HIV RNA) and/or further HIV antibody testing. If the contact is found to be HIV positive, immediate referral should be made to a HIV specialist.

Infants

- Children born to HIV-positive women should be referred to a specialist in pediatric infectious diseases for assessment as soon as possible after delivery.
- For infants born to HIV-positive mothers who have not taken antiretroviral prophylaxis, perinatal transmission can still be significantly reduced by starting antiretroviral therapy as soon as possible after birth, preferably within one to four hours following birth.
- A specialist in pediatric infectious diseases should be consulted in all cases.
- HIV-positive mothers should not breastfeed.

Management of Occupational Exposures

- Transmission of HIV infection in the workplace (occupational exposure) is primarily concerned with the potential for transmission from patient to health care personnel.
- Occupational exposure to HIV infection may occur in several instances:
    - Percutaneous injury with a sharp object potentially contaminated with blood or other bodily fluid.
    - Mucous membrane exposure to blood or other bodily fluid.
    - Skin exposure to blood or other bodily fluid.
- The average risk of HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.3% (3/1,000), and after a mucous membrane exposure, approximately 0.09% (0.9/1,000).
- The risk for transmission after exposure to fluids or tissues other than HIV-infected blood also has not been quantified, but is probably considerably lower than for blood exposures.
- The decision to initiate post-exposure prophylaxis (PEP) medications for HIV infection is based on clinical judgment and should be a joint decision with the exposed health care worker based on source and exposure factors.
- **If PEP is indicated, it should be initiated as soon as possible, as it may be less effective if initiated more than 72 hours after exposure.**

Management of Clients from Citizenship Immigration Canada (CIC)

A large number of new immigrants to Canada are from regions in the world with rates of HIV infection several times higher than in Canada. HIV infection is not a medical condition for which medical surveillance is imposed on an applicant's visa by Citizen and Immigration Canada (CIC) unlike T.B and syphlis. However since 2004 CIC undertook the initiative to inform provincial /territorial (P/T) public health authorities who had elected to receive the information of all HIV positive cases identified during immigration medical examination process and destined to their province.

As of June 2013 Newfoundland and Labrador will receive nominal information each month following the arrival of these individuals in the province. The purpose of the notification is:

• To allow public health authorities to communicate with the individuals as soon as possible so that early linkage with the provincial medical system is established.

• To ensure that public health activities deemed necessary are undertaken early and appropriately.

The immigration medical exam (IME) is performed by a Designated Medical Practitioner (DMP) and is completed in the country of origin before arrival in Canada. It consists of a:

- Medical History.
- Physical examination.
- Urinalysis for applicants >5 years of age.
- Chest x-ray for applicants 15 years of age and above.

Individuals found to be HIV positive during their immigration medical examination (IME) are informed of their status and are provided with HIV Post-Test Counseling by a CIC Panel Physician before moving to Canada.

The applicant receives a “Health Follow up Handout: HIV infection” from the immigration officers once their visa is approved. This letter provides the individual

with provincial contact information and encourages the individual to contact the 1 800 number provided so that they may obtain information to assist the individual in gaining early access to support, care and treatment. In NL the number on the handout is 1 800 563 1575 (ACNL).

NL reporting process:

1. CIC notifies Department of Health and Community Services (DHCS), Government of Newfoundland and Labrador of all out-of-country immigrants testing positive for HIV monthly if there is a case.

2. DHCS notifies appropriate RHA of immigrants who have tested positive for HIV.

3. The Disease Control Nurse Specialist (DCNS) contacts the Regional Medical Officer of Health (RMOH) and regional Communicable Disease Control Nurse(CDCN).

4. The CDCN makes contact with the individual to offer information on support and services and to encourage the individual to re-test within NL. A referral to the HIV clinic may be determined to be appropriate.

RHA follow up process:

1. The CDCN will attempt contact the individual by registered letter.

Unlike TB and syphilis there is no notice of medical compliance associated with HIV notification.

2. Once a confirmatory lab test is complete immigrants who are positive are reported in the Communicable Disease Surveillance System (CDSS) as HIV infection, previously diagnosed, first time tested in Canada.

3. If unable to contact person due to an out of province move the DCN will be notified by the CDCN, subsequently CIC will be advised of this information.

The second method of identifying immigration–related HIV cases in NL is through routine provincial reporting and public health follow-up. Some individuals settle first within Newfoundland and Labrador and then initiate the immigration proceeding. These individuals undertake their IME within NL and are not reported to Disease Control by CIC if they test positive for HIV. Instead the positive lab report is reported to the Disease Control Division by the public health laboratory services where all confirmatory HIV testing is conducted for the province. Once a positive lab report is received it is entered into the CDSS and the RHA where the client resides completes the follow up.

Management of Outbreaks

An outbreak management team should be established to address infection prevention and control measures.

PREVENTION

Education

- Prevention and public health programs should be offered to reduce HIV transmission through IDU (e.g., needle exchange programs and harm reduction strategies).
- Confidential HIV testing should be made available in facilities where individuals may be at higher risk of contracting HIV (i.e., correctional facilities, drug treatment centers, and STI clinics, establishments that offer services to MSM, homeless shelters, and group homes).
- Health care practitioners should recommend to all STI cases and contacts that they be tested for HIV.
- All pregnant women should be counseled regarding HIV testing and prenatal blood work should include HIV screening unless the woman opts out. Those found to be positive should be advised of the recommendation for antiretroviral medications to prevent vertical transmission.
- Provide public education about the safe handling of blood, body fluids, and sharps disposal.
- Prompt treatment of any STI will reduce the risk of acquiring and transmitting HIV infection.
- Infection Control Routine Practices should be in place in health care facilities to prevent exposure of health care workers to blood and body fluids.
- Health care or public safety worker should follow standard blood/body fluids

precautions and safely handle needles and other sharps.

Risk factors common to HIV infection

- Focus on methods to reduce high risk sexual behaviors that may lead to HIV or STIs (e.g., safer sex education).
- HIV post-exposure prophylaxis *(*PEP) should be considered for non-occupational exposures and sexual assaults in consultation with an infectious disease specialist.
- School health programs should center on basic and accurate information about STIs, safer sex, HIV, and unintended pregnancies.
- Family physicians should be targeted for education to increase and normalize HIV testing, to offer HIV testing as part of routine examinations and to increase awareness about the changing epidemiology of HIV/AIDS.
- Anyone considering tattooing, body piercing, or acupuncture should be counselled to ensure that these practices are carried out with sterile equipment, preferably single use equipment.

DOCUMENTS

1. STI Treatment/Contact Tracing form
2. Confidential Medical Matter letter for clients
3. Physician Letter re: HIV Lab Report and Case Report
4. HIV Lab Report and Case Report: Public Health Agency of Canada

1. STI Treatment and Contact Tracing follow-up Letter

STI TREATMENT & CONTACT TRACING FOLLOW-UP LETTER

To: _____ Clinic: _____

Report attached for: _____ MCP#: _____

Disease reported ( ) Chlamydia ( ) Gonorrhea Lab Confirmed ( ) Yes ( ) No Date Collected:

Please complete the following sections

CLIENT INFORMATION

DOB: or Age:	Address: Phone # (H) (Cell)	
Marital Status ( ) Single ( ) Married or Com Law ( ) Separated/Divorced	Sexual Preference □ Sex with females only □ Sex with males only □ Sex with males & females	Risk Factors (check all that apply) ( ) Sexual contact of confirmed case ( ) High risk partner ( ) ≥ 2 partners in past 6 months ( ) Unprotected sex ( ) Infant born to case ( ) Sexual Assault ( ) Condom failure ( ) Alcohol/drug use ( ) Sex trade ( ) Other:

DISEASE INFORMATION

Date of Onset of Symptoms:	Is case pregnant? ( ) Y ( ) N ( ) N/A
Chlamydia Treatment Prescribed: ( ) Azithromycin 1 gm ( ) Doxycycline 100 mg bid x 7days ( ) Other _____	Gonorrhea Treatment Prescribed: ( ) Ceftriaxone 250 mg IM and Azithromycin 1gm ( ) Cefixime 800mg and Azithromycin 1 gm ( ) Other _____
_____/_____/_____ Date Treated	_____ Signature of Physician or RN Date

PLEASE INDICATE IF YOU WISH COMMUNICABLE DISEASE CONTROL TO FOLLOW UP WITH SEXUAL CONTACTS: ( ) YES ( ) NO ( ) CDC TO FOLLOW UP DIRECTLY WITH CASE ( ) CONTACT INFORMATION UNKNOWN

CONTACT INFORMATION (photocopy this sheet if more than one contact or provide separate list of names & contact information)

Last Name / Alias:	First Name:
Address (street, apt #, community)	Phone # (H) (Cell)
DOB ____/____/____ or Age ____ ( ) Male ( ) Female Place of Employment: _____ or Name of School (if student): _____ Physical Description: _____ Marital Status: ( ) Single ( ) Married or Com Law ( ) Separated/Divorced Living with ( ) Case ( ) Parents ( ) Other _____ Pregnant: ( ) Yes ( ) No ( ) N/A	
Relationship to case: ( ) Married/Com Law ( ) Casual ( ) Reg. partner ( ) Sex trade	Exposure Dates (1st) ____/____/____ to ____/____/____ ( ) Unprotected sex ( ) Protected sex
Will your clinic follow-up this contact? ( ) Yes ( ) No	Will your patient notify this contact? ( ) Yes ( ) No
Comments:	

Please fax completed form to 752-4873

_____ _____

Communicable Disease Control Nurse Date

2. Confidential Medical Matter letter for clients

Date:

To:

Re: **Confidential Medical Matter**

Please contact me concerning a confidential medical matter.

My office phone number is _____.

Business hours are Monday – Friday 08:30 am – 4:30 pm.

Thanking you in advance.

_____
Communicable Disease Nurse
Eastern Health
Communicable Disease Control Program

3. Physician Letter re: HIV Lab Report and Case Report

MEDICAL CONFIDENTIAL

RE:

MCP:

Dear Dr.;

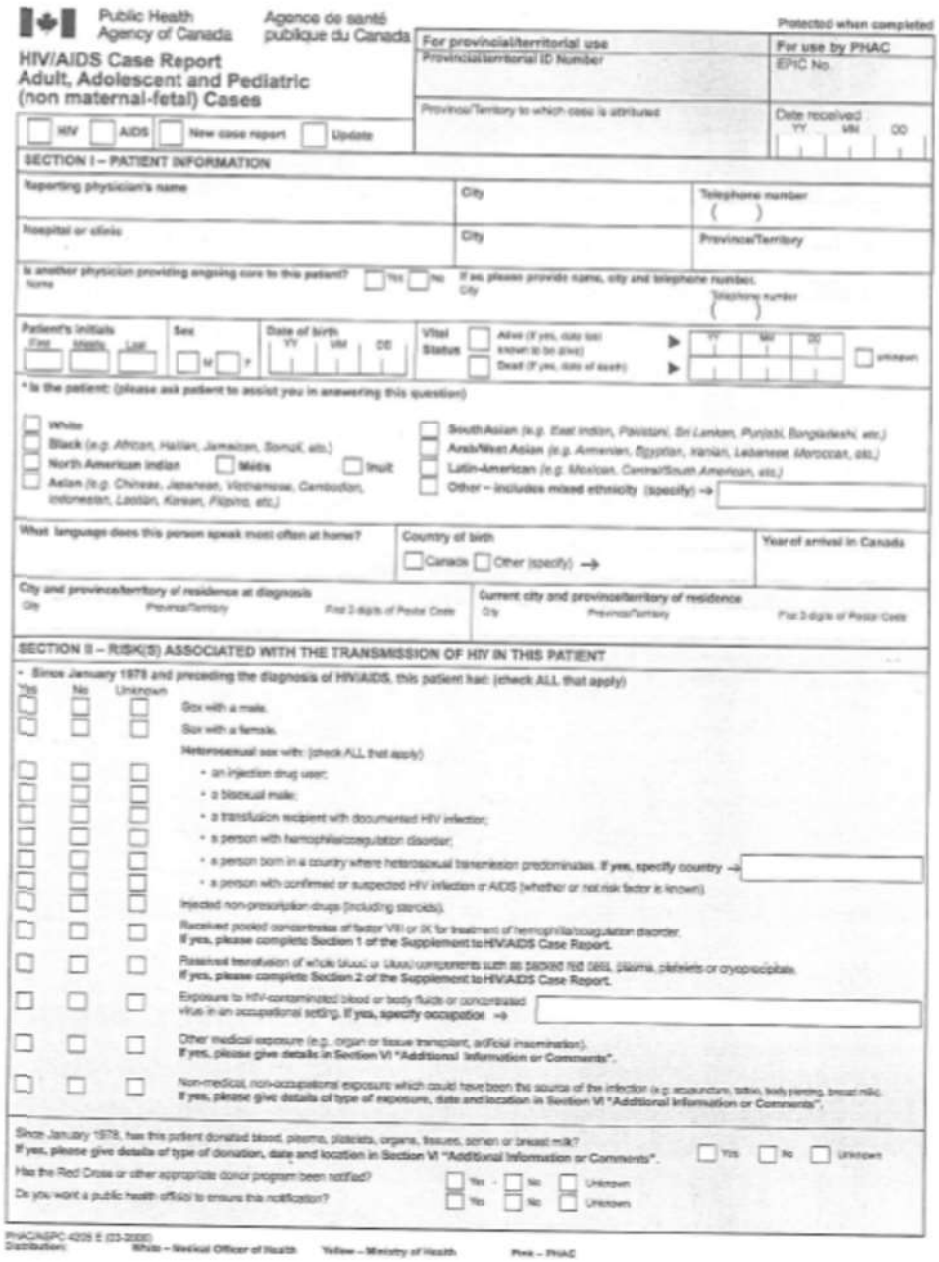
A positive HIV report has been received from the Public Health Laboratory on the above stated patient.

To ensure accurate reporting of this disease, in accordance with the provincial Communicable Disease Act 1998, please complete the attached form and return to the Communicable Disease Control Department.

Thank you for your cooperation in this matter. Feel free to contact me if you have any questions or concerns at _____.

Sincerely,

4. HIV Lab Report and Case Report: Public Health Agency of Canada



Public Health Agency of Canada / Agence de santé publique du Canada

Protected when completed

HIV/AIDS Case Report
Adult, Adolescent and Pediatric
(non maternal-fetal) Cases

For provincial/territorial use
Provincial/territorial ID Number
Province/Territory to which case is attributed

For use by PHAC
EPIC No.
Date received: YY MM DD

☐ HIV ☐ AIDS ☐ New case report ☐ Update

SECTION I – PATIENT INFORMATION

Reporting physician's name | City | Telephone number ( )

Hospital or clinic | City | Province/Territory

Is another physician providing ongoing care to this patient? ☐ Yes ☐ No If yes, please provide name, city and telephone number.
Name | City | Telephone number ( )

Patient's initials: First | Middle | Last
Sex: ☐ M ☐ F
Date of birth: YY MM DD
Vital Status: ☐ Alive (If yes, date last known to be alive) ▶ YY MM DD ☐ unknown
☐ Dead (If yes, date of death) ▶

* Is the patient: (please ask patient to assist you in answering this question)

☐ White
☐ Black (e.g. African, Haitian, Jamaican, Somali, etc.)
☐ North American Indian ☐ Métis ☐ Inuit
☐ Asian (e.g. Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Laotian, Korean, Filipino, etc.)
☐ South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, etc.)
☐ Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan, etc.)
☐ Latin-American (e.g. Mexican, Central/South American, etc.)
☐ Other – includes mixed ethnicity (specify) →

What language does this person speak most often at home?
Country of birth: ☐ Canada ☐ Other (specify) →
Year of arrival in Canada

City and province/territory of residence at diagnosis: City | Province/Territory | First 3 digits of Postal Code
Current city and province/territory of residence: City | Province/Territory | First 3 digits of Postal Code

SECTION II – RISK(S) ASSOCIATED WITH THE TRANSMISSION OF HIV IN THIS PATIENT

* Since January 1978 and preceding the diagnosis of HIV/AIDS, this patient has: (check ALL that apply)

Yes	No	Unknown	
☐	☐	☐	Sex with a male.
☐	☐	☐	Sex with a female.
			Heterosexual sex with: (check ALL that apply)
☐	☐	☐	• an injection drug user;
☐	☐	☐	• a bisexual male;
☐	☐	☐	• a transfusion recipient with documented HIV infection;
☐	☐	☐	• a person with hemophilia/coagulation disorder;
☐	☐	☐	• a person born in a country where heterosexual transmission predominates. If yes, specify country →
☐	☐	☐	• a person with confirmed or suspected HIV infection or AIDS (whether or not risk factor is known).
☐	☐	☐	Injected non-prescription drugs (including steroids).
☐	☐	☐	Received pooled concentrates of factor VIII or IX for treatment of hemophilia/coagulation disorder. If yes, please complete Section 1 of the Supplement to HIV/AIDS Case Report.
☐	☐	☐	Received transfusion of whole blood or blood components such as packed red cells, plasma, platelets or cryoprecipitate. If yes, please complete Section 2 of the Supplement to HIV/AIDS Case Report.
☐	☐	☐	Exposure to HIV-contaminated blood or body fluids or concentrated virus in an occupational setting. If yes, specify occupation →
☐	☐	☐	Other medical exposure (e.g. organ or tissue transplant, artificial insemination). If yes, please give details in Section VI "Additional Information or Comments".
☐	☐	☐	Non-medical, non-occupational exposure which could have been the source of the infection (e.g. acupuncture, tattoo, body piercing, breast milk). If yes, please give details of type of exposure, date and location in Section VI "Additional Information or Comments".

Since January 1978, has this patient donated blood, plasma, platelets, organs, tissues, semen or breast milk? ☐ Yes ☐ No ☐ Unknown
If yes, please give details of type of donation, date and location in Section VI "Additional Information or Comments".
Has the Red Cross or other appropriate donor program been notified? ☐ Yes ☐ No ☐ Unknown
Do you want a public health official to ensure this notification? ☐ Yes ☐ No ☐ Unknown

PHAC/ASPC 4208 E (03-2000)
Distribution: White – Medical Officer of Health Yellow – Ministry of Health Pink – PHAC