

Kentucky Health Information Exchange (KHIE)

Human Immunodeficiency Virus (HIV) Case Report:

Adult HIV & Pediatric HIV

User Guide

July 2024

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1 Introduction

Overview

This training manual covers the unique functionalities for the Adult HIV and Pediatric HIV conditions in the HIV eICR Form in the ePartnerViewer. The Adult HIV condition contains unique **Patient Information, Laboratory Information, Additional Information, Service Referrals, Treatment Information,** and **Additional Comments** screens. The Pediatric HIV condition contains unique **Patient Information, Birth History, Additional Information, Service Referrals, Treatment Information,** and **Additional Comments** screens. All other screens for the Adult HIV and Pediatric HIV conditions follow the generic workflow for the eICR case reports.

Users with the *Manual Case Reporter* role can submit case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (eICR) which is routed to the Kentucky Department for Public Health (KDPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

Please Note: All screenshots shown throughout this document reflect how Users would interact with the ePartnerViewer while using a desktop or tablet device. While core functionality remains the same across multiple devices, interface components may vary in presentation.

Supported Web Browsers

Users must access the ePartnerViewer with a supported web browser. The ePartnerViewer is configured to support the following modern browsers on desktop, tablet, and mobile devices:

Desktop Browser Version	Mobile Browser Version
Microsoft Edge	
Version 44+	Version 40+
Google Chrome	
Version 70+	Version 70+
Mozilla Firefox	
Version 48+	Version 48+
Apple Safari	
Version 9+	iOS 11+

Please Note: The ePartnerViewer does **not** support Microsoft Internet Explorer. To access the ePartnerViewer, Users must use a modern browser such as Google Chrome, Microsoft Edge, Apple Safari, or Mozilla Firefox.

Mobile Device Considerations

The ePartnerViewer is based on responsive design. This means it renders in the best format based on the user's device size. Responsive design applies to mobile, tablet, and desktop devices. Tablet devices in landscape display mode are considered desktop.

Accessing the ePartnerViewer

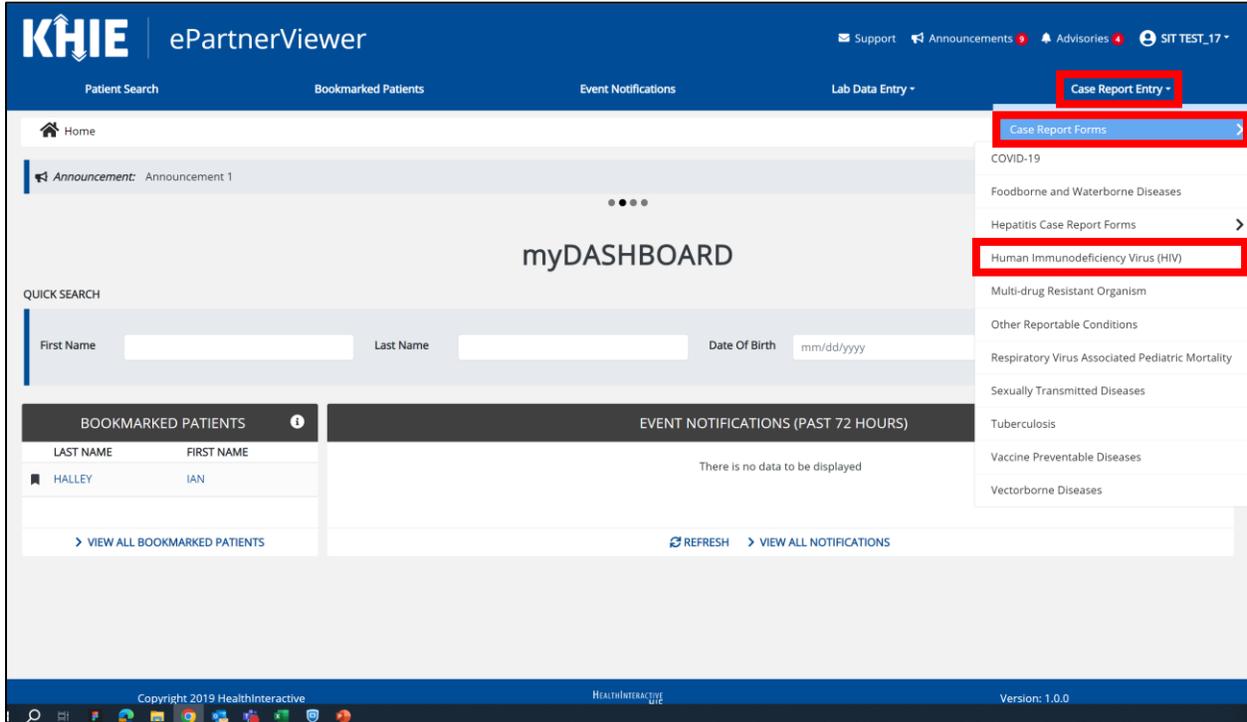
To access the ePartnerViewer, Users must meet the following specifications:

1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

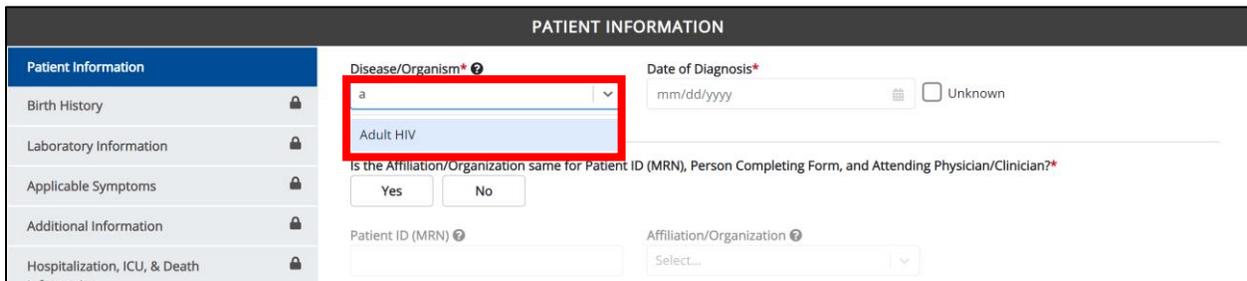
Please Note: For specific information about creating a Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

2 Adult HIV Patient Information

1. To enter Human Immunodeficiency Virus (HIV) case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.
2. Select **Human Immunodeficiency Virus (HIV)** from the dropdown menu.



3. To start the Adult HIV Case Report entry, select **Adult HIV** from the *Disease/Organism* field on the **Patient Information** screen.



Please Note: Case Reports for Adult HIV must be submitted only for patients **older than 13 years of age**.

4. You must complete the mandatory fields on the **Patient Information** screen.

Disease/Organism* Date of Diagnosis* Unknown

This form should be completed for Adult HIV/AIDS cases only when the patient is 13 years of age or older.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Yes No

Patient ID (MRN) Affiliation/Organization

Person Completing Form Affiliation/Organization If other, please specify:

Attending Physician/Clinician Affiliation/Organization If other, please specify:

Prefix

First Name* Middle Name Last Name*

Suffix Date of Birth*

Patient Sex* Ethnicity* Race*

Alias First Name Alias Last Name

5. Enter the **Date of Diagnosis**. If the date of diagnosis is unknown, click the **Unknown** checkbox.

Disease/Organism* Date of Diagnosis* Unknown

6. Select the **appropriate answer** for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*

Yes No

Patient ID (MRN) Affiliation/Organization

Person Completing Form Affiliation/Organization If other, please specify:

- Click **Yes** to apply the **same** Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
*

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? Select... v	
Person Completing Form* Select... v	Affiliation/Organization ? Select... v	If other, please specify: ? <input type="text"/>
Attending Physician/Clinician* Select... v	Affiliation/Organization ? Select... v	If other, please specify: ? <input type="text"/>

- Click **No** to select a **different** Affiliation/Organization for the Patient ID (MRN), Person Completing Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
*

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? Select... v	
Person Completing Form* Select... v	Affiliation/Organization* ? Select... v	If other, please specify: ? <input type="text"/>
Attending Physician/Clinician* Select... v	Affiliation/Organization* ? Select... v	If other, please specify: ? <input type="text"/>

- Enter the patient's **Medical Record Number (MRN)** in the *Patient ID (MRN)* field. An MRN is an organization specific, unique identification number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you **MUST** create a way to uniquely identify your patient so that the patient is registered in the KHIE system.

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? Select... v
--	---

- 8. From the dropdown menu, select the **Affiliation/Organization** that applies to the Patient ID (MRN).

Please Note: If **Yes** is selected for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?* the same Affiliation/Organization will apply to each. The *Affiliation/Organization* field is enabled only for the Patient ID (MRN).

- 9. From the dropdown menu, select the name of the **Person Completing Form**.

- 10. If applicable, select the **Affiliation/Organization** that applies to the Person Completing the Form.

Please Note: The *Affiliation/Organization* field that applies to the Person Completing Form is enabled only if you selected **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

11. Select the **Attending Physician/Clinician** from the dropdown menu.

12. If applicable, select the **Affiliation/Organization** that applies to the physician attending the patient.

Please Note: The *Affiliation/Organization* field that applies to the Attending Physician/Clinician is enabled only when you select **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

13. If available for the patient, select the **Prefix** and **Suffix** from the dropdown menus.

14. Enter the patient's **First Name** and **Last Name**.

15. If available, enter the patient's **Middle Name**.

16. Enter the patient's **Date of Birth**.

17. Select the **Patient Sex** from the dropdown menu.

18. Select the patient's **Ethnicity** and **Race** from the appropriate dropdown menus.

The screenshot shows a form with three dropdown menus highlighted in red: 'Patient Sex*' (with 'Select...' selected), 'Ethnicity*' (with 'Not Hispanic or Latino' selected), and 'Race*' (with 'Select...' selected and a list of options open). The 'Race*' dropdown list includes: American Indian or Alaska Native, Asian, Asked but Unknown, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and Unknown. Below these are fields for Address 1*, Address 2, City*, State*, County*, and Phone*.

19. Enter the patient's **Street Address, City, State, Zip Code,** and **County.**

20. Enter the patient's **Phone Number.**

21. If available, enter the patient's **Email Address.**

The screenshot shows a form with several fields highlighted in red: Address 1*, Address 2 (with placeholder 'Unit, Suite, Building, etc.'), City*, State* (with 'Select...' selected), Zip Code*, County* (with 'Select...' selected), Phone* (with placeholder '(xxx) xxx-xxxx'), and Email (with placeholder 'name@domain.com').

22. If applicable, enter the **patient's alias** in the textboxes for the field: *Alias First Name* and *Alias Last Name*.

The screenshot shows two textboxes highlighted in red: 'Alias First Name' and 'Alias Last Name'.

23. Select the **type of patient visit** from the *Visit Type* dropdown menu.

The screenshot shows a form with a 'Visit Type*' dropdown menu highlighted in red. The dropdown is open, showing options: Ambulatory, Emergency, Field, Home Health, Inpatient Acute, Inpatient Encounter, Inpatient Non-Acute, and Unknown. To the right is a field for 'Encounter ID/Visit #' with a 'Generate' button.

- The *Encounter ID/Visit #* field allows Users to enter a **unique 20-digit Encounter ID/Visit #**.

A screenshot of a form section. On the left, there is a dropdown menu labeled "Visit Type*" with "Ambulatory" selected. To its right is a text input field labeled "Encounter ID/Visit #*" with a question mark icon. This input field is highlighted with a red rectangular box. To the right of the input field is a checkbox labeled "Generate".

- The **Encounter ID/Visit #** hyperlink allows Users to view the *Patient Case History* which includes the historical case report details and Encounter IDs (when available) that were previously submitted for the patient. The *Patient Case History* search is based on the **Patient First Name, Last Name,** and **Patient ID (MRN)** entered.

A screenshot of the same form section. The "Encounter ID/Visit #*" text is now a blue hyperlink and is highlighted with a red rectangular box. The "Generate" checkbox is still present to the right.

- The **Generate** checkbox triggers the system to generate a **unique 20-digit Encounter ID/Visit #** if the Encounter ID/Visit # is unknown.

A screenshot of the form section. The "Generate" checkbox is highlighted with a red rectangular box. The "Encounter ID/Visit #" field is currently empty.

- Upon clicking the **Generate** checkbox, the *Encounter ID/Visit #* field will be grayed out and disabled. The *Encounter ID/Visit #* field will display the system-generated Encounter ID/Visit # only after the **Patient Information** screen has been completed and saved.

A screenshot of the form section. The "Encounter ID/Visit #" field is now grayed out and contains a system-generated value. The "Generate" checkbox is checked and highlighted with a red rectangular box.

24. Select the **appropriate answer** for the conditional question: *Was the patient's address at the time of diagnosis the same as the patient's current address?*

A screenshot of a form section. At the top, a question is highlighted with a red box: "Was the patient's address at the time of diagnosis the same as the patient's current address?*" Below the question are three radio button options: "Yes", "No", and "Unknown". Below the options is the instruction: "Please enter the address where the patient lived at the time of diagnosis." The form contains several input fields: "Address 1", "Address 2" (with a sub-label "Unit, Suite, Building, etc."), "City", "State" (a dropdown menu), "Zip Code", and "County" (a dropdown menu).

- 25. If **No** is selected for the conditional question, the subsequent address fields on the screen are enabled. You must complete the required fields on the screen.
- 26. Enter the address where the patient was living at the time of diagnosis. Include the **Street Address, City, State, Zip Code, and County**.

Was the patient's address at the time of diagnosis the same as the patient's current address?*

Please enter the address where the patient lived at the time of diagnosis.

Address 1*

Address 2

City*

State*

Zip Code*

County*

- 27. If known, enter the **patient's Social Security Number** in the textbox for the field: *What is the patient's social security number?*
 - Click the **eye icon** to show the values entered in the textbox.

What is the patient's social security number? ⓘ

What is the patient's social security number? ⓘ

000-00-0000

- 28. Select the **appropriate answer** from the dropdown menu for the conditional question: *What was the patient's sex assigned at birth?*

What was the patient's sex assigned at birth?*

Is the patient currently pregnant?

If yes, please enter the due date (EDC). ⓘ

Unknown

Has the patient delivered liveborn infants?

Has the patient been receiving or been referred for gynecological or obstetrical services?

Did the patient recently deliver?

If yes, please enter the date of delivery.

Unknown

- 29. If **Female** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.
- 30. Select the **appropriate answer** for the conditional question: *Is the patient currently pregnant?*

- If **Yes** is selected for the *Is the patient currently pregnant?* field, the subsequent field is enabled. Enter the **estimated due date (EDC)** in the subsequent field: *If yes, please enter the due date (EDC)*. If the due date is unknown, click the **Unknown** checkbox.

- 31. Select the **appropriate answers** for the following fields:

- *Has the patient delivered liveborn infants?*
- *Has the patient been receiving or been referred for gynecological or obstetrical services?*
- *Did the patient recently deliver?*

32. Select the **appropriate answer** for the conditional question: *Did the patient recently deliver?*

Did the patient recently deliver?*

Yes No Unknown

If yes, please enter the date of delivery.

mm/dd/yyyy Unknown

33. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.

34. Enter the **Date of Delivery**. If the date of delivery is unknown, click the **Unknown** checkbox.

Did the patient recently deliver?*

Yes No Unknown

If yes, please enter the date of delivery.*

mm/dd/yyyy Unknown

35. Select the **appropriate answer** for the field: *Was the infant delivered at the reporting facility?*

Was the infant delivered at the reporting facility?*

Yes No Unknown

36. Select the **appropriate answer** from the dropdown menu for the field: *What is the patient's gender identity?*

What is the patient's gender identity?*

Select...

- Another gender identity
- Female
- Male
- Transgender female
- Transgender male
- Unknown
- Other

37. If **Other** is selected, enter the **patient's other gender identity** in the textbox for the field: *If other, please specify.*

What is the patient's gender identity?*

Other

If other, please specify.*

38. Select the **appropriate answer** from the dropdown menu for the field: *What is the patient's country of birth?*

What is the patient's country of birth?*

Select...

- United States
- Afghanistan
- Albania
- Algeria
- Andorra
- Angola
- Antigua and Barbuda

Please enter the name of the facility that made the initial diagnosis.

39. Select the **appropriate answer** from the dropdown menu for the field: *What is the patient's sexual orientation?*

What is the patient's sexual orientation?*

Select...

- Lesbian or gay
- Straight
- Bisexual
- Other
- Prefer not to answer

Please enter the name of the facility that made the initial diagnosis.

40. If **Other** is selected, enter the **patient's other sexual orientation** in the textbox for the field: *If other, please specify.*

What is the patient's sexual orientation?*

Other

If other, please specify.*

41. Select the **appropriate answer** for the field: *Is the facility providing this case information the same facility that made the initial diagnosis?*

Is the facility providing this case information the same facility that made the initial diagnosis?

Yes No

Please enter the name of the facility that made the initial diagnosis.

0/300 Characters

42. If **No** is selected, enter the **name of the facility that made the initial diagnosis**, if known.

43. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Birth History** screen.

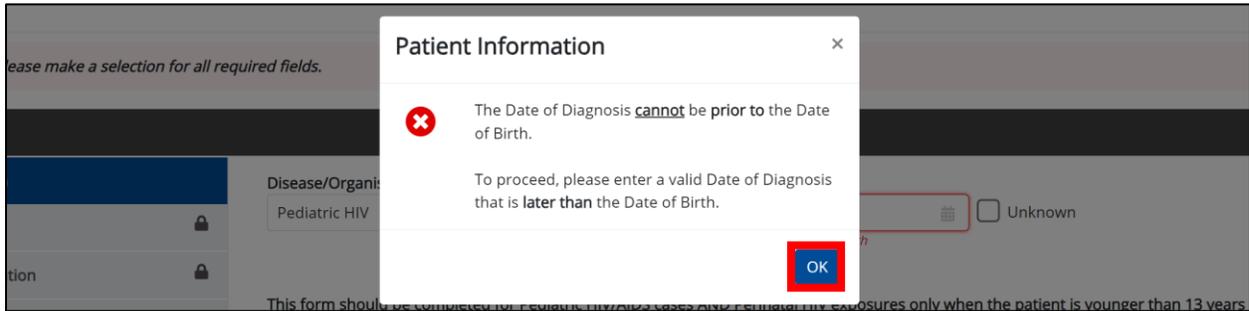
44. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered indicates the patient is younger than 13 years of age.

- *The Date of Diagnosis entered indicates the patient is younger than 13 years of age at the time of diagnosis. If the patient is younger than 13 years of age, then this information should be reported as Pediatric HIV. Please select **Pediatric HIV** from the dropdown menu in the "Disease/Organism" field.*

45. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis** to indicate the patient is younger than 13 years of age.

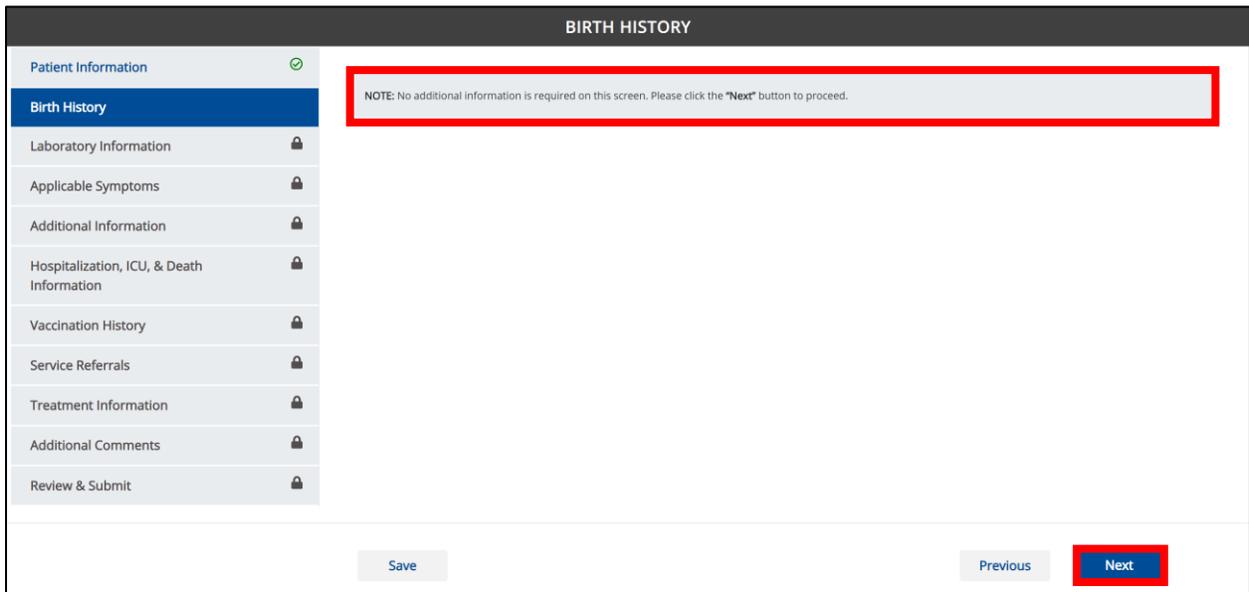
46. To log the information as a Pediatric HIV Case Report, select **Pediatric HIV** from the *Disease/Organism* field.

- 47. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered occurs before the patient’s Date of Birth.
- 48. The Date of Diagnosis cannot be **prior to** the Date of Birth. To proceed, please enter a valid Date of Diagnosis that is **later than** the Date of Birth.
- 49. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis**.



3 Adult HIV Birth History

- 1. On the **Birth History** screen, the following message displays at the top: **NOTE: No additional information is required on this screen. Please click the “Next” button to proceed.**
- 2. Click **Next** to proceed to the **Laboratory Information** screen.



4 Adult HIV Laboratory Information

1. On the **Laboratory Information** screen, select the **appropriate answer** for the conditional question at the top: *Has the patient ever had a previous positive HIV test result?*

LABORATORY INFORMATION

Patient Information

Birth History

Laboratory Information

Applicable Symptoms

Additional Information

Has the patient ever had a previous positive HIV test result?*

Yes No Unknown

If Yes, please enter the positive HIV test result date.

Month Day Year

2. If **Yes** is selected, enter the **positive HIV test result date** in the *Month, Day, and Year* dropdown menus for the field: *If Yes, please enter the positive HIV test result date.*

LABORATORY INFORMATION

Has the patient ever had a previous positive HIV test result?*

Yes No Unknown

If Yes, please enter the positive HIV test result date.

Month* Day* Year*

3. Select the **appropriate answer** for the conditional question at the top: *Has the patient ever had a previous negative HIV test result?*

Has the patient ever had a previous negative HIV test result?*

Yes No Unknown

If Yes, please enter the negative HIV test result date.

Month Day Year

4. If **Yes** is selected, enter the **negative HIV test result dates** in the *Month, Day, and Year* dropdown menus for the field: *If Yes, please enter the negative HIV test result date.*

If Yes, please enter the negative HIV test result date.

Month* Day* Year*

5. Select the **appropriate answer** for the conditional question: *Does the patient have a lab test?*

Does the patient have a lab test?*

Yes No Unknown

- 6. If **Yes** is selected, the subsequent laboratory-related fields on the screen are enabled. You must enter details for a lab test.

Does the patient have a lab test?*

Laboratory Information

Please enter the most recent positive and negative HIV laboratory test results.

Laboratory Name*

Test Name* ?

Select... | v

If other, please specify. ?

Common Brand/Test Kit Name*

Select... | v

Is this a point of care (POC) test?

Select... | v

EHE/KY/Evaluation Web Number ?

Filler Order/Accession Number ?

Specimen Source*

Select... | v

- 7. Enter the **Laboratory Name** in the textbox.

Please enter the most recent positive and negative HIV laboratory test results.

Laboratory Name*

8. Select the **Test Name** from the *Test Name* dropdown menu.

Test Name* ⓘ

Select...

- CD3+CD4+ (T4 helper) cells [# /volume] in Blood
- CD3+CD4+ (T4 helper) cells/100 cells in Blood
- HIV 1+2 Ab and HIV1 p24 Ag [Identifier] in Serum, Plasma or Blood by Rapid immunoassay
- HIV 1+2 Ab [Presence] in Serum, Plasma or Blood by Rapid immunoassay
- HIV 1+2 Ab [Presence] in Specimen by Rapid immunoassay
- HIV 1+2 Ab+HIV1 p24 Ag [Presence] in Serum or Plasma by Immunoassay
- HIV 1+2 RNA [Presence] in Serum or Plasma by NAA with probe detection

9. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Name** in the subsequent textbox: *If other, please specify.*

Test Name* ⓘ

Other x | v

If other, please specify.* ⓘ

10. Select the **Common Brand/Test Kit Name** from the dropdown menu.

Test Name* ⓘ

HIV 1+2 Ab [Presence] in Serum, Plasma or Blood by Rapid immunoassay x | v

If other, please specify. ⓘ

Common Brand/Test Kit Name*

Select...

- HIV 1/2 STAT-PAK Assay
- INSTI HIV-1/HIV-2 Antibody Test
- Sure Check HIV 1/2 Assay

11. Select the **appropriate answer** from the dropdown menu for the field: *Is this a point of care (POC) test?*

Is this a point of care (POC) test?

Select...

- No
- Unknown
- Yes

- 12. If applicable, enter the **EHE/KY Evaluation Web Number** in the textbox.
- 13. If applicable, enter the **Filler Order/Accession Number** in the textbox.

EHE/KY/Evaluation Web Number ?
[Red-bordered empty text box]

Filler Order/Accession Number ?
[Red-bordered empty text box]

- 14. Select the appropriate **Specimen Source** from the *Specimen Source* dropdown menu.

Specimen Source*
Select...
Abscess
Amniotic fluid
Aspirate
Bile fluid
Blood
Blood (arterial)
Blood (capillary)

- 15. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Specimen Source** in the subsequent textbox: *If other, please specify.*

Specimen Source*
Other
If other, please specify.* ?
[Red-bordered empty text box]

- 16. Select the **appropriate Test Result** from the *Test Result* dropdown menu.

Test Result*
Select...
HIV 1 indeterminate
HIV 1 positive
HIV 2 indeterminate
HIV 2 positive
HIV Ab positive and Ag positive
HIV Ag (p24) positive
HIV indeterminate

17. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Result** in the subsequent textbox: *If other, please specify.*

18. Enter the **Test Result Date**.

19. Enter the **Specimen Collection Date**.

20. If applicable, enter **additional notes about the lab tests** in the *Additional Information* textbox.

50. When the **Laboratory Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Applicable Symptoms** screen.

5 Adult HIV Applicable Symptoms

1. On the **Applicable Symptoms** screen, select the appropriate answer for the conditional question at the top: *Were symptoms present during the course of illness?*

2. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled.

Please Note: If **No** is selected for the conditional question, all subsequent symptom fields are disabled and marked with **No**. If **Unknown** is selected for the conditional question, all subsequent symptom fields are disabled and marked as **Unknown**.

3. Enter the **Onset Date** for the symptoms.
 - If the onset date is unknown, click the **Unknown** checkbox.

- 4. To report whether the patient had a fever during the illness, select the **appropriate answer** for the field: *Fever*.

If symptomatic, which of the following did the patient experience during illness?

Fever*

If yes, please enter the highest temperature. ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient's highest temperature** in the subsequent textbox: *If yes, please enter the highest temperature.*

Fever*

If yes, please enter the highest temperature.* ?

- 5. To report the patient had diarrhea during the illness, select the **appropriate answer** for the field: *Diarrhea (>3 loose stools/24hr period)*.

Diarrhea (>3 loose stools/24hr period)*

If yes, please enter the number of days with diarrhea. ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **number of days with diarrhea** in the subsequent textbox: *If yes, please enter the number of days with diarrhea.*

Diarrhea (>3 loose stools/24hr period)*

If yes, please enter the number of days with diarrhea.* ?

6. Select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Chills* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	Myalgia* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Lymphadenopathy* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	Night sweats* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Malaise* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	Pharyngitis* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Mouth ulcers* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	Rash* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

7. To report additional symptoms not listed on the screen, select the **appropriate answer** for the field: *Did the patient have any other symptoms?*

Did the patient have any other symptoms?*

<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
------------------------------------	-----------------------------------	--

If yes, please specify. ⓘ

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient’s other symptoms** in the subsequent textbox: *If yes, please specify.*

8. Once complete, click **Next** to proceed to the **Additional Information** screen.

Did the patient have any other symptoms?*

<input checked="" type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
---	-----------------------------------	--

If yes, please specify.* ⓘ

Other symptoms

6 Adult HIV Additional Information

1. On the **Additional Information** screen, the following question displays at the top of the screen:
After 1977 and before the earliest known diagnosis of HIV infection, has the patient had any of the following?

ADDITIONAL INFORMATION

After 1977 and before the earliest known diagnosis of HIV infection, has the patient had any of the following?

Sex with male(s)*

Yes	No	Unknown
-----	----	---------

Sex with female(s)*

Yes	No	Unknown
-----	----	---------

Injected nonprescription drugs*

Yes	No	Unknown
-----	----	---------

2. Select the **appropriate answers** for the following fields:
 - *Sex with male(s)*
 - *Sex with female(s)*
 - *Injected nonprescription drugs*

ADDITIONAL INFORMATION

After 1977 and before the earliest known diagnosis of HIV infection, has the patient had any of the following?

Sex with male(s)*

Yes	No	Unknown
-----	----	---------

Sex with female(s)*

Yes	No	Unknown
-----	----	---------

Injected nonprescription drugs*

Yes	No	Unknown
-----	----	---------

- 3. Select the **appropriate answer** for the conditional question: *Received clotting factor for hemophilia/coagulation disorder.*

- 4. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.

- 5. Select the **clotting factor** from the dropdown menu for the field: *If yes, please specify the clotting factor that the patient received.*

- 6. If **Other** is selected, enter the **other clotting factor that the patient** received in the textbox for the field: *If yes, other please specify.*

- 7. Enter the **date the clotting factor was received** in the *Date Received* field. If the date received is unknown, click the **Unknown** checkbox.

Date Received*

mm/dd/yyyy Unknown

- 8. The **Additional Information** screen displays the following question: *Has the patient had any heterosexual relations with any of the following?*
- 9. Select the **appropriate answers** for the following fields:
 - *Heterosexual contact with intravenous/injection drug user*
 - *Heterosexual contact with bisexual male*
 - *Heterosexual contact with person with hemophilia/coagulation disorder with documented HIV infection*
 - *Heterosexual contact with transfusion recipient with documented HIV infection*
 - *Heterosexual contact with transplant recipient with documented HIV infection*
 - *Heterosexual contact with person with documented HIV infection, risk not specified*

Has the patient had any heterosexual relations with any of the following?

Heterosexual contact with intravenous/injection drug user*

Yes No Unknown

Heterosexual contact with bisexual male*

Yes No Unknown

Heterosexual contact with person with hemophilia/coagulation disorder with documented HIV infection*

Yes No Unknown

Heterosexual contact with transfusion recipient with documented HIV infection*

Yes No Unknown

Heterosexual contact with transplant recipient with documented HIV infection*

Yes No Unknown

Heterosexual contact with person with documented HIV infection, risk not specified*

Yes No Unknown

Please Note: Some fields may be disabled based on the User's selections on the **Patient Information** screen for the field: *What is the patient's sexual orientation?*

10. Select the **appropriate answer** for the conditional question: *Has the patient received a transfusion of blood/blood components (other than clotting factor)?*

Has the patient received a transfusion of blood/blood components (other than clotting factor)?*

Yes No Unknown

If yes, please specify the reason for the transfusion.

0/300 Characters

First Received Date mm/dd/yyyy Unknown

Last Received Date mm/dd/yyyy Unknown

11. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.

12. Enter the **reason for the transfusion** in the textbox for the field: *If yes, please specify the reason for the transfusion.*

13. Enter the **First Received Date** and **Last Received Date**. If the first received date or last received date are unknown, click the **Unknown** checkbox.

Has the patient received a transfusion of blood/blood components (other than clotting factor)?*

Yes No Unknown

If yes, please specify the reason for the transfusion.*

0/300 Characters

First Received Date* mm/dd/yyyy Unknown

Last Received Date* mm/dd/yyyy Unknown

14. Select the **appropriate answer** for the field: *Has the patient received a transplant of tissue/organs or artificial insemination?*

Has the patient received a transplant of tissue/organs or artificial insemination?*

Yes No Unknown

15. Select the **appropriate answer** for the conditional question: *Has the patient worked in a healthcare or clinical lab setting?*

Has the patient worked in a healthcare or clinical lab setting?*

Yes No Unknown

Is occupational exposure being investigated or considered as the primary mode of exposure?

Yes No Unknown

If yes, please specify the occupation.

16. If **Yes** is selected for the conditional question, select the **appropriate answer** for the field: *Is occupational exposure being investigated or considered as the primary mode of exposure?*

17. If **Yes** is selected for the conditional question, select the **appropriate answer** from the dropdown menu for the field: *If yes, please specify the occupation.*

18. If **Other** is selected, enter the **other occupation** in the textbox for the field: *If other, please specify.*

- 19. If applicable, enter the **details for any other documented risk(s)** in the textbox for the field:
Please include other documented risk(s), if applicable.
- 20. Once complete, click **Next** to proceed to the **Hospitalization, ICU, & Death Information** screen.

Please include other documented risk(s), if applicable.

0/500 Characters

7 Adult HIV Hospitalization, ICU, & Death Information

- 1. On the **Hospitalization, ICU, & Death Information** screen, select the **appropriate answer** for the conditional question at the top: *Was the patient hospitalized?*

HOSPITALIZATION, ICU, & DEATH INFORMATION

Patient Information	✔	Was the patient hospitalized?*
Birth History	✔	<input style="border: 2px solid red;" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Laboratory Information	✔	If yes, please specify the hospital name. ⓘ
Applicable Symptoms	✔	
Additional Information	✔	Admission Date Discharge Date

- 2. If **Yes** is selected for the conditional question, the subsequent hospitalization-related and ICU-related fields on the screen are enabled. You must complete the required fields.

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name.* ⓘ

Admission Date* Unknown Discharge Date* Unknown

Still hospitalized

Was the patient admitted to an intensive care unit (ICU)?*

Yes No Unknown

Admission Date to ICU Unknown Discharge Date from ICU Unknown

Please Note: If **No** or **Unknown** is selected for the conditional question, all subsequent hospitalization-related and ICU-related fields are disabled. Death-related questions are not impacted by the selected answer for the conditional question: *Was the patient hospitalized?*

- 3. If applicable, select the **appropriate answer** for the field: *Did the patient die as a result of this illness?*

Did the patient die as a result of this illness?*

Yes No

If yes, please provide the date of death.

Date of Death

mm/dd/yyyy

Please Note: If the **Still Hospitalized** checkbox is selected, the death-related fields are disabled.

Admission Date* 04/29/2024 Unknown

Discharge Date* mm/dd/yyyy Unknown

Still hospitalized

Was the patient admitted to an intensive care unit (ICU)?*

Yes No Unknown

Admission Date to ICU mm/dd/yyyy Unknown

Discharge Date from ICU mm/dd/yyyy Unknown

Did the patient die as a result of this illness?

Yes No

If yes, please provide the date of death.

Date of Death

mm/dd/yyyy

- 4. If **Yes** is selected, the subsequent *Date of Death* field is enabled. Enter the patient's **Date of Death**.

Did the patient die as a result of this illness?*

Yes No

If yes, please provide the date of death.

Date of Death*

mm/dd/yyyy

- 5. Once complete, click **Next** to proceed to the **Vaccination History** screen.

If yes, please provide the date of death.

Date of Death

mm/dd/yyyy

Save Previous **Next**

8 Adult HIV Vaccination History

1. On the **Vaccination History** screen, the following message displays at the top: **NOTE: No additional information is required on this screen. Please click the "Next" button to proceed.**
2. Click **Next** to proceed to the **Service Referrals** screen.

9 Adult HIV Service Referrals

1. On the **Service Referrals** screen, select the appropriate answer for the conditional question at the top: *Has the patient been informed of his/her HIV infection?*

- 2. If **Yes** is selected, select the **appropriate answer** from the dropdown menu for the field: *Other than the laboratory test result, is there other evidence that the patient received HIV medical care?*

- 3. If **Yes, client self-report only** or **Yes, documented** is selected, enter the **Date of Evidence**. If the date of evidence is unknown, click the *Unknown* checkbox.

- 4. Select the **appropriate answer** for the conditional question: *Is the patient receiving services or been referred for HIV medical services?*

- 5. If **Yes** is selected, enter the **details of the clinic(s)** for the field: *Please enter the name(s) of the clinic(s) where the patient has been referred or is receiving treatment for HIV care.*

- 6. Once complete, click **Next** to proceed to the **Treatment Information** screen.

10 Adult HIV Treatment Information

1. On the **Treatment Information** screen, select the appropriate answer for the conditional question at the top: *Has the patient been prescribed any antiretroviral (ARV) medications?*

TREATMENT INFORMATION

Has the patient been prescribed any antiretroviral (ARV) medications?*

Is the patient currently adhering to the prescribed medication regimen?

2. If **Yes** is selected, the subsequent treatment-related fields on the screen are enabled. You must enter details for treatment information.

TREATMENT INFORMATION

Has the patient been prescribed any antiretroviral (ARV) medications?*

Is the patient currently adhering to the prescribed medication regimen?*

Treatment Information

Treatment Start Date* Unknown

Last Received Date* Unknown

Ongoing Treatment

Medication*

If other, please specify.

Reason for Treatment*

If other, please specify.

Additional Information

0/300 Characters

Please Note: If **No** or **Unknown** is selected for the conditional question, all subsequent fields are disabled.

- 3. Select the **appropriate answer** for the field: *Is the patient currently adhering to the prescribed medication regimen?*

Is the patient currently adhering to the prescribed medication regimen?*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
------------------------------	-----------------------------	----------------------------------

- 4. Enter the **Treatment Start Date** and **Last Received Date**. If the treatment start date or last received date are unknown, click the respective **Unknown** checkboxes.
- 5. If the treatment is ongoing, click the **Ongoing Treatment** checkbox.

Treatment Information

Treatment Start Date* Unknown

Last Received Date* Unknown

Ongoing Treatment

- 6. Select the **appropriate Medication** from the *Medication* dropdown menu.

Medication*

- Agenerase (amprenavir)
- Apretude (cabotegravir)
- Aptivus (tipranavir)
- Atripla (efavirenz/emtricitabine/tenofovir DF)
- Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide)
- Cabenuva (cabotegravir/rilpivirine)
- Cimduo/Temixys (lamivudine/tenofovir disproxil fumarate)

- 7. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **name of the medication** in the subsequent textbox: *If other, please specify.*

Medication*

If other, please specify.*

8. Select the **appropriate Reason for Treatment** from the *Reason for Treatment* dropdown menu.

9. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **reason for treatment** in the subsequent textbox: *If other, please specify*.

10. If applicable, enter **additional notes about the treatment** in the *Additional Information* textbox.

Adding Multiple Treatments

11. Click **Add Treatment** to log the details for multiple treatments. This means that you can easily enter additional treatment details on the same patient.

Please Note: When you click the **Add Treatment** button, you must enter the details for at least one treatment.

12. To delete an additional treatment section, click the **Trash Bin Icon** located at the top right.

The screenshot shows a form titled "Treatment Information". At the top right, there is a red square icon of a trash bin. Below the title, there are two date fields: "Treatment Start Date*" and "Last Received Date*", each with a calendar icon and an "Unknown" checkbox. Below these is an "Ongoing Treatment" checkbox. The "Medication*" field is a dropdown menu with "Select..." and a downward arrow, followed by a text input field for "If other, please specify.". The "Reason for Treatment*" field is also a dropdown menu with "Select..." and a downward arrow, followed by a text input field for "If other, please specify.". At the bottom is an "Additional Information" text area with a character count of "0/300 Characters".

13. Once complete, click **Next** to proceed to the **Additional Comments** screen.

The screenshot shows a navigation bar with a blue plus icon and the text "Add Treatment" on the left. On the right, there are three buttons: "Save", "Previous", and "Next". The "Next" button is highlighted with a red border.

11 Adult HIV Additional Comments

1. On the **Additional Comments** screen, select the appropriate answer for the conditional question at the top: *Has the patient been diagnosed with an opportunistic illness since the onset of HIV symptoms or concurrent with HIV diagnosis?*

The screenshot shows the 'ADDITIONAL COMMENTS' header. On the left, there are two tabs: 'Patient Information' and 'Birth History', both with green checkmarks. The main content area contains the question: 'Has the patient been diagnosed with an opportunistic illness since the onset of HIV symptoms or concurrent with HIV diagnosis?*' Below the question are three radio button options: 'Yes', 'No', and 'Unknown'. The 'Yes' option is selected and highlighted with a red box.

2. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.

This screenshot shows the 'ADDITIONAL COMMENTS' screen with the 'Yes' radio button selected. Below the question, there are three radio button options: 'Yes', 'No', and 'Unknown'. Underneath, there is a section titled 'Opportunistic Illness' with the prompt 'Please specify the opportunistic illness.*'. A dropdown menu is open, showing 'Select...' and a downward arrow. Below the dropdown is a text input field with the placeholder 'If other, please specify.'. At the bottom, there is a 'Date of Diagnosis*' field with a calendar icon and the placeholder 'mm/dd/yyyy'.

3. Select the **opportunistic illness** from the dropdown menu for the field: *Please specify the opportunistic illness.*

This screenshot shows the dropdown menu for the 'Please specify the opportunistic illness.*' field. The dropdown is open, showing a list of opportunistic illnesses. The first option, 'Candidiasis, bronchi, trachea, or lungs', is highlighted in blue. Other options include 'Candidiasis, esophageal', 'Carcinoma, invasive cervical', 'Coccidioidomycosis, disseminated or extrapulmonary', 'Cryptococcosis, extrapulmonary', 'Cryptosporidiosis, chronic intestinal (>1 mo. duration)', and 'Cytomegalovirus disease (other than in liver, spleen, or nodes)'.

- 4. If **Other** is selected, enter the **other opportunistic illness** in the textbox for the field: *If other, please specify.*

Please specify the opportunistic illness.*

Other x | v

If other, please specify.*

- 5. Enter the **Date of Diagnosis**. If the date of diagnosis is unknown, click the **Unknown** checkbox.

Date of Diagnosis* ⓘ

mm/dd/yyyy

Adding Multiple Opportunistic Illnesses

- 6. Click **Add Opportunistic Illness** to log the details for opportunistic illnesses. This means that you can easily enter additional opportunistic illness details on the same patient.

Date of Diagnosis* ⓘ

06/10/2024

+ Add Opportunistic Illness

Please Note: When you click the **Add Opportunistic Illness** button, you must enter the details for at least one opportunistic illness.

- 7. To delete an additional opportunistic illness section, click the **Trash Bin Icon** located at the top right.

Opportunistic Illness

Please specify the opportunistic illness.*

Select... | v

If other, please specify.

Date of Diagnosis* ⓘ

mm/dd/yyyy

- 8. If applicable, enter **additional notes about the opportunistic illness** in the textbox: *Please include additional comments or notes, if applicable.*
- 9. Once complete, click **Next** to proceed to the **Review and Submit** screen.

Please include additional comments or notes, if applicable.

0/1000 Characters

Save Previous Next

12 Adult HIV Review and Submit

1. On the **Review and Submit** screen, review the summary of information you have entered. Click the **appropriate section header** to make edits to the section's information.

REVIEW & SUBMIT

Patient Information ✓

Birth History ✓

Laboratory Information ✓

Applicable Symptoms ✓

Additional Information ✓

Hospitalization, ICU, & Death Information ✓

Vaccination History ✓

Service Referrals ✓

Treatment Information ✓

Additional Comments ✓

Review & Submit

Print Download

Patient Information

Disease/Organism: Adult HIV | Date of Diagnosis: 2024/06/04

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes

Patient ID (MRN): HI4562135 | Affiliation/Organization: Atrium Health

Person Completing Form: Dr. Niles Crane (niles@mailinator.com) | Affiliation/Organization: Atrium Health

Attending Physician/Clinician: Dr. Frank Costanza, Sr (frankc@email.com) | Affiliation/Organization: Atrium Health

First Name: Jane | Last Name: Doe

Date of Birth: 1999/12/12

2. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Adult HIV Case Report Entry.

Additional Comments

Previous Submit

3. All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.

Case Report Entry

All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.

Cancel Submit

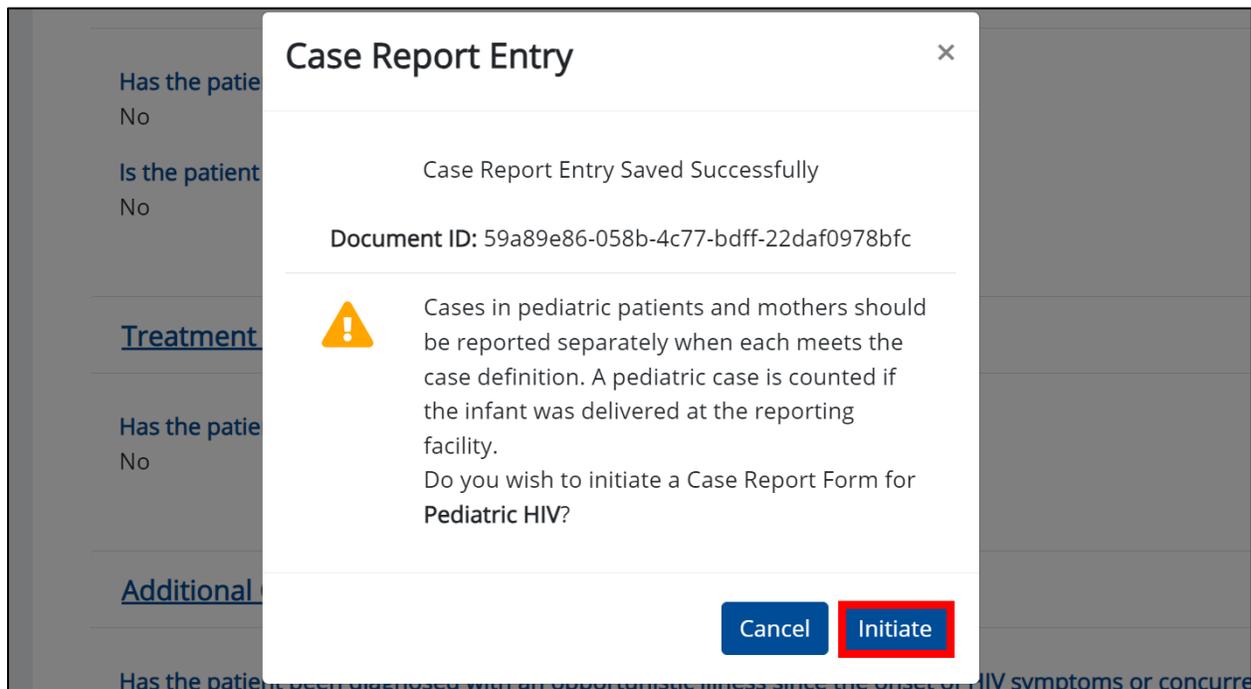
Please Note: Once a case report has been submitted, it is final. Should you later discover that you have entered inaccurate information, please use the **Support Tab** in the ePartnerViewer to report this information.

4. If **Yes** was selected for the *Was the infant delivered at the reporting facility?* field on the **Patient Information** screen, then the *Case Report Entry* pop-up displays the following message:

- *Cases in pediatric patients and mothers should be reported separately when each meets the case definition. A pediatric case is counted if the infant was delivered at the reporting facility. Do you wish to initiate a Case Report Form for **Pediatric HIV**?*



5. This pop-up allows you to create a new Pediatric HIV Case Report Form for the patient’s child. To initiate a Pediatric Case Report for the patient’s child, click **Initiate** on the pop-up.



Please Note: Upon clicking **Initiate** on the *Case Report Entry* pop-up, you are automatically navigated to the **Patient Information** screen of the Human Immunodeficiency Virus (HIV) Case Report with **Pediatric HIV** preselected for the *Disease/Organism* field.

13 Pediatric HIV Patient Information

1. Upon clicking **Initiate** on the *Case Report Entry* pop-up after submitting the Adult HIV Case Report, you are automatically navigated to the **Patient Information** screen of the Human Immunodeficiency Virus (HIV) Case Report with **Pediatric HIV** preselected for the *Disease/Organism* field.

PATIENT INFORMATION

Disease/Organism* ?
Pediatric HIV x | v

Date of Diagnosis*
mm/dd/yyyy Unknown

This form should be completed for Pediatric HIV/AIDS cases AND Perinatal HIV exposures only when the patient is younger than 13 years of age.

2. You must complete the mandatory fields on the **Patient Information** screen.

PATIENT INFORMATION

Disease/Organism* ?
Pediatric HIV x | v

Date of Diagnosis*
mm/dd/yyyy Unknown

This form should be completed for Pediatric HIV/AIDS cases AND Perinatal HIV exposures only when the patient is younger than 13 years of age.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Yes No

Patient ID (MRN) ? Affiliation/Organization ?
Select... Select...

Person Completing Form Affiliation/Organization ? If other, please specify. ?
Select... Select...

Attending Physician/Clinician Affiliation/Organization ? If other, please specify. ?
Select... Select...

Prefix
Select... | v

First Name* Middle Name Last Name*

Suffix Date of Birth*
Select... mm/dd/yyyy

Patient Sex* Ethnicity* Race*
Select... Select... Select... | v

3. Enter the **Date of Diagnosis**. If the Date of Diagnosis is unknown, click the **Unknown** checkbox.

Disease/Organism* ?
Pediatric HIV x | v

Date of Diagnosis*
mm/dd/yyyy Unknown

- 4. Select the **appropriate answer** for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*

Yes No

Patient ID (MRN) ? Affiliation/Organization ?

Person Completing Form Affiliation/Organization ? If other, please specify: ?

- Click **Yes** to apply the **same** Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Yes No

Patient ID (MRN)* ? Affiliation/Organization* ?

Person Completing Form* Affiliation/Organization ? If other, please specify: ?

Attending Physician/Clinician* Affiliation/Organization ? If other, please specify: ?

- Click **No** to select a **different** Affiliation/Organization for the Patient ID (MRN), Person Completing Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Yes No

Patient ID (MRN)* ? Affiliation/Organization* ?

Person Completing Form* Affiliation/Organization* ? If other, please specify: ?

Attending Physician/Clinician* Affiliation/Organization* ? If other, please specify: ?

- 5. Enter the patient's **Medical Record Number (MRN)** in the *Patient ID (MRN)* field. An MRN is an organization specific, unique identification number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you **MUST** create a way to uniquely identify your patient so that the patient is registered in the KHIE system.
- 6. From the dropdown menu, select the **Affiliation/Organization** that applies to the Patient ID (MRN).

Please Note: If **Yes** is selected for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?* the same Affiliation/Organization will apply to each. The *Affiliation/Organization* field is enabled only for the Patient ID (MRN).

- 7. From the dropdown menu, select the name of the **Person Completing Form**.

- 8. If applicable, select the **Affiliation/Organization** that applies to the Person Completing the Form.

Please Note: The *Affiliation/Organization* field that applies to the Person Completing Form is enabled only if you selected **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

9. Select the **Attending Physician/Clinician** from the dropdown menu.

10. If applicable, select the **Affiliation/Organization** that applies to the physician attending the patient.

11. If available for the patient, select the **Prefix** and **Suffix** from the dropdown menus.

12. Enter the patient's **First Name** and **Last Name**.

13. If available, enter the patient's **Middle Name**.

14. Enter the patient's **Date of Birth**.

15. Select the **Patient Sex** from the dropdown menu.

16. Select the patient's **Ethnicity** and **Race** from the appropriate dropdown menus.

The screenshot shows a form with several fields. Three dropdown menus are highlighted with red boxes: 'Patient Sex*' (with 'Select...' selected), 'Ethnicity*' (with 'Not Hispanic or Latino' selected), and 'Race*' (with a list of options including 'American Indian or Alaska Native', 'Asian', 'Asked but Unknown', 'Black or African American', 'Native Hawaiian or Other Pacific Islander', 'Other', and 'Unknown'). Other fields include 'Address 1*', 'Address 2', 'City*', 'State*', 'County*', and 'Phone*'.

17. Enter the patient's **Street Address, City, State, Zip Code,** and **County.**

18. Enter the patient's **Phone Number.**

19. If available, enter the patient's **Email Address.**

The screenshot shows the same form as above, but with text input fields highlighted in red: 'Address 1*', 'Address 2', 'City*', 'State*', 'Zip Code*', 'County*', 'Phone*', and 'Email'.

20. If applicable, enter the **patient's alias** in the textboxes for the field: *Alias First Name* and *Alias Last Name*.

The screenshot shows two text input fields: 'Alias First Name' and 'Alias Last Name', both highlighted with red boxes.

21. Select the **type of patient visit** from the *Visit Type* dropdown menu.

The screenshot shows a 'Visit Type*' dropdown menu with options: 'Ambulatory', 'Emergency', 'Field', 'Home Health', 'Inpatient Acute', 'Inpatient Encounter', and 'Inpatient Non-Acute'. The dropdown is highlighted in red. To its right is an 'Encounter ID/Visit #' field with a 'Generate' button and an 'Unknown' checkbox.

- The *Encounter ID/Visit #* field allows Users to enter a **unique 20-digit Encounter ID/Visit #**.

Visit Type*
Ambulatory x | v

Encounter ID/Visit #* ?

Generate

- The **Encounter ID/Visit #** hyperlink allows Users to view the *Patient Case History* which includes the historical case report details and Encounter IDs (when available) that were previously submitted for the patient. The *Patient Case History* search is based on the **Patient First Name, Last Name,** and **Patient ID (MRN)** entered.

Visit Type*
Select... | v

Encounter ID/Visit #* ?

Generate

- The **Generate** checkbox triggers the system to generate a **unique 20-digit Encounter ID/Visit #** if the Encounter ID/Visit # is unknown.

Visit Type*
Select... | v

Encounter ID/Visit #* ?

Generate

- Upon clicking the **Generate** checkbox, the *Encounter ID/Visit #* field will be grayed out and disabled. The *Encounter ID/Visit #* field will display the system-generated Encounter ID/Visit # only after the **Patient Information** screen has been completed and saved.

Visit Type*
Emergency x | v

Encounter ID/Visit #* ?

Generate

22. Select the **appropriate answer** for the conditional question: *Was the patient's address at the time of diagnosis the same as the patient's current address?*

Was the patient's address at the time of diagnosis the same as the patient's current address?*

Yes No Unknown

Please enter the address where the patient lived at the time of diagnosis.

Address 1 Address 2
Unit, Suite, Building, etc.

City State Zip Code
Select... | v

County
Select... | v

- 23. If **No** is selected for the conditional question, the subsequent address at the time of diagnosis fields on the screen are enabled. You must complete the required fields on the screen.
- 24. Enter the patient's **Street Address, City, State, Zip Code**, and **County at the time of diagnosis**.
- 25. Enter the patient's **Phone Number**.
- 26. If available, enter the patient's **Email Address**.

Was the patient's address at the time of diagnosis the same as the patient's current address?*

Please enter the address where the patient lived at the time of diagnosis.

Address 1*

Address 2

City*

State*

Zip Code*

County*

- 27. If known, enter the **patient's social security number** in the textbox for the filed: *What is the patient's social security number?*
 - Click the **eye icon** to show the values entered in the textbox.

What is the patient's social security number? ⓘ

What is the patient's social security number? ⓘ

000-00-0000

- 28. Select the **appropriate answer** from the dropdown menu for the conditional question: *What was the patient's sex assigned at birth?*

What was the patient's sex assigned at birth?*

Female

Male

that made the initial diagnosis?

- 29. Select the **appropriate answer** for the conditional question: *Is the facility providing this case information the same facility that made the initial diagnosis?*

Is the facility providing this case information the same facility that made the initial diagnosis?

30. If **No** is selected, the subsequent field is enabled. If known, enter the **name of the facility that made the initial diagnosis** in the textbox field: *Please enter the name of the facility that made the initial diagnosis.*

Is the facility providing this case information the same facility that made the initial diagnosis?

Please enter the name of the facility that made the initial diagnosis.

0/300 Characters

31. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Birth History** screen.

32. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered indicates the patient is 13 years of age or older.

33. *The Date of Diagnosis entered indicates the patient is 13 years of age or older at the diagnosis. If the patient is 13 years of age or older, then this information should be reported as Adult HIV.*

34. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis** to indicate the patient is younger than 13 years of age.

35. To log the information as an Adult HIV Case Report, select **Adult HIV** from the *Disease/Organism* field.

Patient Information [X]

The Date of Diagnosis entered indicates the patient is 13 years of age or older at the time of diagnosis. If the patient is 13 years of age or older, then this information should be reported as Adult HIV .

Please select **Adult HIV** from the dropdown in the "Disease/Organism" field.

Disease/Organism*

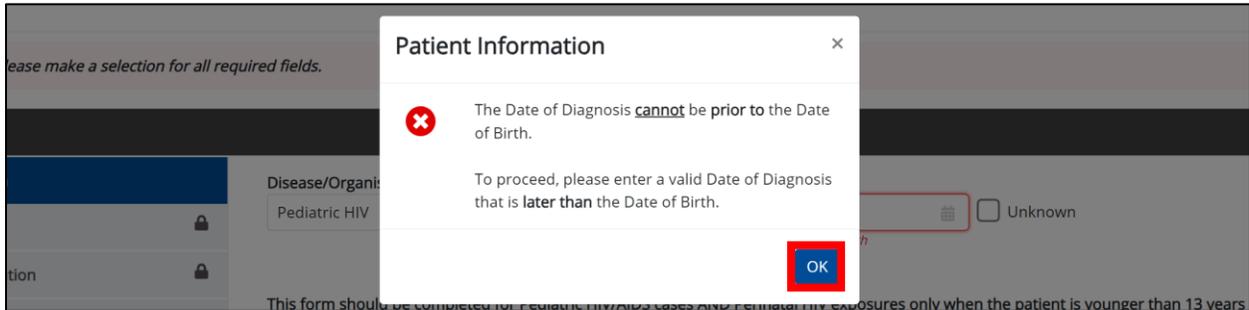
Adult HIV

Date of Diagnosis* Unknown

36. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered occurs before the patient’s Date of Birth.

- *The Date of Diagnosis cannot be **prior to** the Date of Birth. To proceed, please enter a valid Date of Diagnosis that is **later than** the Date of Birth.*

37. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis**.



14 Pediatric HIV Birth History

1. On the **Birth History** screen, select the appropriate answer for the conditional question at the top: *What is the child's birthing person's HIV infection status?*

BIRTH HISTORY

What is the child's birthing person's HIV infection status?*

Select...

- Refused HIV testing
- HIV status unknown
- HIV+ & time of diagnosis unknown
- Known HIV+ after child's birth
- Known HIV+ at delivery
- Known HIV+ before pregnancy
- Known HIV+ during pregnancy

2. If applicable, enter the **date of the birthing person's first positive test that confirmed the infection** in the *Month*, *Day*, and *Year* fields.

Please enter the date of the birthing person's first positive test that confirmed the infection.

Month* ? | Day* ? | Year* ?

Select... | Select... | Select...

Please Note: If *Refused HIV Testing* or *HIV status unknown* are selected for the *What is the child's birthing person's HIV infection status?* field, then the *Month*, *Day* and *Year* fields are disabled.

What is the child's birthing person's HIV infection status?*

Refused HIV testing

Please enter the date of the birthing person's first positive test that confirmed the infection.

Month ? | Day ? | Year ?

Select... | Select... | Select...

3. Select the **appropriate answer** for the field: *Was the child's birthing person counseled regarding HIV testing during the pregnancy, labor, or delivery?*

Was the child's birthing person counseled regarding HIV testing during this pregnancy, labor, or delivery? *

Yes | No | Unknown

- 4. Select the **appropriate answer** from down menu for the field: *Please specify if this form is being completed for a perinatal HIV exposure or pediatric HIV/AIDS case.*

Please specify if this form is being completed for a perinatal HIV exposure or pediatric HIV/AIDS case.*

Select...

Pediatric HIV/AIDS case

Perinatal HIV exposure

What is the patient's country of birth?

Please Note: Upon clicking **Next** to proceed to the **Applicable Symptoms** screen, Users will not be able to change the selection for the field: *Please specify if this form is being completed for a perinatal HIV exposure or pediatric HIV/AIDS case.*

- 5. Select the **appropriate answer** for the conditional question: *Is the patient's birth history available?*

Is the patient's birth history available?*

Yes No Unknown

- 6. If **Yes** is selected, select the **appropriate answer** from the dropdown menu for the field: *What is the patient's country of birth.*

What is the patient's country of birth?

Select...

United States

Afghanistan

Albania

Algeria

Andorra

Angola

Antigua and Barbuda

- 7. Select the **appropriate answer** for the conditional question: *Was the patient's address at the time of diagnosis the same as the patient's current address?*

Was the patient's address at the time of diagnosis the same as the patient's current address?*

Yes No Unknown

Please enter the address where the patient lived at the time of diagnosis.

Address 1 Address 2
Unit, Suite, Building, etc.

City State Zip Code
Select...

- 8. If **No** is selected for the conditional question, the subsequent address at the time of diagnosis fields on the screen are enabled. You must complete the required fields on the screen.
- 9. Enter the address where the patient was living at the time of diagnosis. Include the **Street Address, City, State, Zip Code, and County**.

Was the patient's address at the time of diagnosis the same as the patient's current address?*

Please enter the address where the patient lived at the time of diagnosis.

Address 1*

Address 2

City*

State*

Zip Code*

County*

- 10. Select the **appropriate answer** for the conditional question: *Was the patient's address at the time of birth the same as the patient's current address?*

Is the facility providing this case information the same facility where the patient was born?

- 11. If **No** is selected for the conditional question, the subsequent facility contact information fields on the screen are enabled. You must complete the required fields on the screen.
- 12. Enter the **Facility Name, Street Address, City, State, Zip Code, and County** of the facility where the patient was born.
- 13. Enter the **Phone Number** of the facility where the patient was born.
- 14. If applicable, enter the **Email** of the facility where the patient was born.

Is the facility providing this case information the same facility where the patient was born?

Please enter the contact information of the facility where the patient was born.

Facility Name*

Address 1*

Address 2

City*

State*

Zip Code*

County*

Phone*

Email

15. Enter the **patient's birth weight** in the *lb* and *oz* textboxes.

What was the patient's birth weight?

lb	oz
----	----

16. Select the **appropriate answer** for the dropdown menu for the field: *What was the pregnancy type?*

What was the pregnancy type?

Select...

- More than two
- Single
- Twin
- Unknown

17. Select the **appropriate answer** for the dropdown menu for the field: *What was the delivery type?*

What was the delivery type?

Select...

- Cesarean
- Unknown
- Vaginal

18. Select the **appropriate answer** for the conditional question: *Did the patient have any birth defects?*

Did the patient have any birth defects?*

Yes	No	Unknown
-----	----	---------

If yes, please specify the birth defect(s).

0/300 Characters

19. If **Yes** is selected, enter the **patient's birth defect(s)** in the textbox for the field: *If yes, please specify the birth defect(s).*

Did the patient have any birth defects?*

Yes	No	Unknown
-----	----	---------

If yes, please specify the birth defect(s).*

0/300 Characters

20. Select the **appropriate answer** for the dropdown menu for the field: *What was the neonate's status upon delivery?*

What was the neonate's status upon delivery?

Select...

- Full-term
- Premature
- Unknown

21. Enter the **gestational age of the fetus at the time of delivery in weeks and days** in the *Weeks* and *Days* textboxes for the field: *What was the gestational age of the fetus at the time of delivery?* Please enter the age in weeks and days.

What was the gestational age of the fetus at the time of delivery? Please enter the age in weeks and days.

Weeks* ? Days* ?

of Weeks # of Days

22. If known, enter the **gestational age of the fetus when prenatal care visits began**. Enter the **age in weeks** in the *Weeks* textbox for the field: *At what gestational age did prenatal care visits begin?*

At what gestational age did prenatal care visits begin?

Weeks

of Weeks

23. If known, enter the **total number of prenatal care visits** in the textbox for the field: *What was the total number of prenatal care visits?*

What was the total number of prenatal care visits? ?

24. Select the **appropriate answer** for the conditional question: *Did the birthing person receive any antiretrovirals (ARVs) prior to this pregnancy?*

Did the birthing person receive any antiretrovirals (ARVs) prior to this pregnancy?

Yes No Unknown Refused

If yes, please specify the antiretrovirals (ARVs).

0/200 Characters

Date of First Use Date of Last Use

mm/dd/yyyy Unknown mm/dd/yyyy Unknown

- 25. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.
- 26. If known, enter the **ARVs taken prior to this pregnancy** in the textbox for the field: *If yes, please specify the antiretrovirals (ARVs).*
- 27. Enter the **Date of First Use** and **Date of Last Use**. If the date of first use or date of last use are unknown, click the **Unknown** checkbox.

Did the birthing person receive any antiretrovirals (ARVs) prior to this pregnancy?

Yes No Unknown Refused

If yes, please specify the antiretrovirals (ARVs).

0/200 Characters

Date of First Use Unknown

Date of Last Use Unknown

- 28. Select the **appropriate answer** for the conditional question: *Did the birthing person receive any antiretrovirals (ARVs) during pregnancy?*

Did the birthing person receive any antiretrovirals (ARVs) during pregnancy?

Yes No Unknown Refused

- 29. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.
- 30. If known, enter the **ARVs taken during pregnancy** in the textbox for the field: *If yes, please specify the antiretrovirals (ARVs).*
- 31. Enter the **Date of First Use** and **Date of Last Use**. If the date of first use or date of last use are unknown, click the **Unknown** checkbox.

Did the birthing person receive any antiretrovirals (ARVs) during pregnancy?

Yes No Unknown Refused

If yes, please specify the antiretrovirals (ARVs).

0/200 Characters

Date of First Use Unknown

Date of Last Use Unknown

- 32. Select the **appropriate answer** for the conditional question: *Did the birthing person receive any antiretrovirals (ARVs) during labor/delivery?*

Did the birthing person receive any antiretrovirals (ARVs) during labor/delivery?

Yes No Unknown Refused

- 33. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.
- 34. If known, enter the **ARVs taken during labor/delivery** in the textbox for the field: *If yes, please specify the antiretrovirals (ARVs).*
- 35. Enter the **Date of First Use** and **Date of Last Use**. If the date of first use or date of last use are unknown, click the **Unknown** checkbox.

Did the birthing person receive any antiretrovirals (ARVs) during labor/delivery?

If yes, please specify the antiretrovirals (ARVs).

0/200 Characters

Date of First Use Unknown

Date of Last Use Unknown

- 36. If known, enter the **First Name**, **Last Name**, and **Date of Birth** of the patient's birthing person.
- 37. If known, enter the **Street Address**, **City**, **State**, **Zip Code**, **County** and **Phone Number** of the patient's birthing person.

Please enter the contact information and DOB of the birthing person.

First Name Last Name Date of Birth

Address 1 Address 2

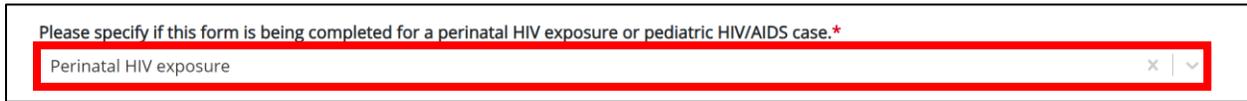
City State Zip Code

County Phone

- 38. Select the **appropriate answer** from the dropdown menu for the field: *What was the child's birthing person's country of birth?*
- 39. Once complete, click **Next** to proceed to the **Laboratory Information** screen.

What is the child's birthing person's country of birth?

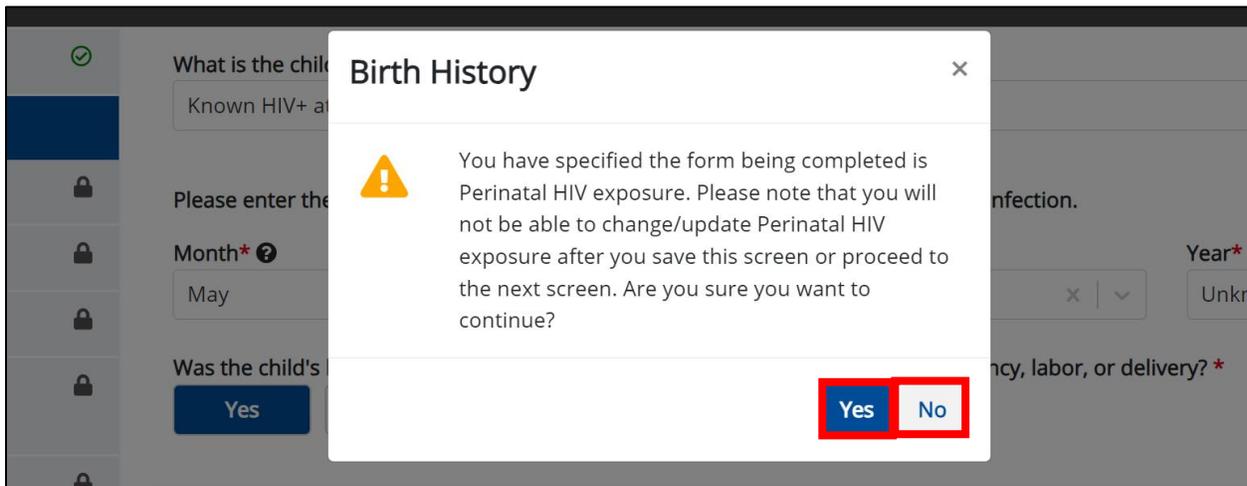
40. Upon clicking **Save** or **Next**, the *Birth History* pop-up displays the following message when you have specified the form is being completed for Perinatal HIV exposure.



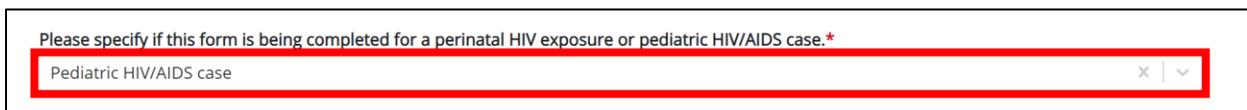
41. You have specified the form being completed is Perinatal HIV exposure. Please note that you will not be able to change/update Perinatal HIV exposure after you save this screen or proceed to the next screen. Are you sure you want to continue?

42. To update the form being completed, click **No** to close the *Birth History* pop-up and select **Pediatric HIV/AIDS case** from the dropdown menu for the field: *Please specify if this form is being completed for a perinatal HIV exposure or Pediatric HIV/AIDS case.*

43. If the information entered is correct, click **Yes** to close the *Birth History* pop-up and proceed to the **Laboratory Information** screen.



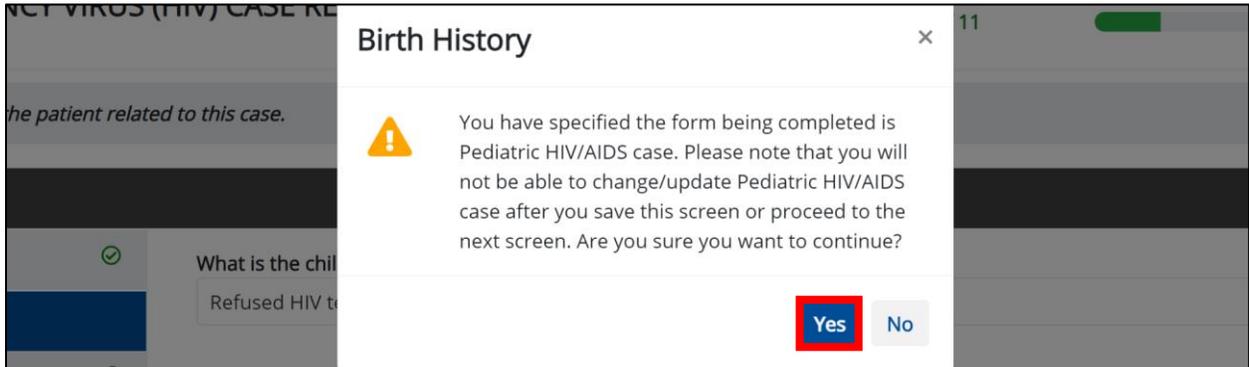
44. Upon clicking **Save** or **Next**, the *Birth History* pop-up displays the following message when you have specified the form is being completed for Pediatric HIV/AIDS case.



- You have specified the form being completed is Pediatric HIV/AIDS case. Please note that you will not be able to change/update Pediatric HIV/AIDS case after you save this screen or proceed to the next screen. Are you sure you want to continue?

45. To update the form being completed, click **No** to close the *Birth History* pop-up and select **Perinatal HIV exposure** from the dropdown menu for the field: *Please specify if this form is being completed for a perinatal HIV exposure or Pediatric HIV/AIDS case.*

- 46. If the information entered is correct, click **Yes** to close the *Birth History* pop-up and proceed to the **Laboratory Information** screen.

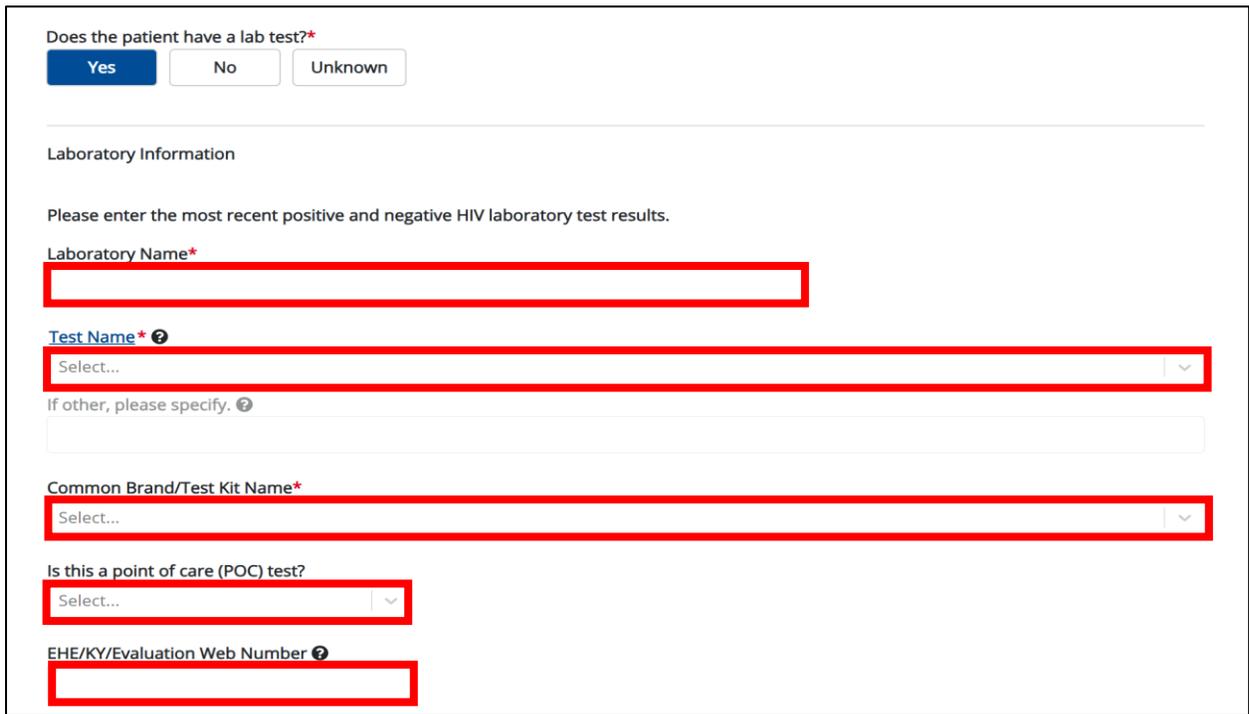


15 Pediatric HIV Laboratory Information

- 1. On the **Laboratory Information** screen, select the **appropriate answer** for the conditional question at the top: *Does the patient have a lab test?*



- 2. If **Yes** is selected, the subsequent laboratory-related fields on the screen are enabled. You must enter details for a lab test.



3. Enter the **Laboratory Name** in the textbox.

Please enter the most recent positive and negative HIV laboratory test results.

Laboratory Name*

4. Select the **Test Name** from the *Test Name* dropdown menu.

Test Name* ?

Select...

- CD3+CD4+ (T4 helper) cells [# /volume] in Blood
- CD3+CD4+ (T4 helper) cells/100 cells in Blood
- HIV 1+2 Ab and HIV1 p24 Ag [Identifier] in Serum, Plasma or Blood by Rapid immunoassay
- HIV 1+2 Ab [Presence] in Serum, Plasma or Blood by Rapid immunoassay
- HIV 1+2 Ab [Presence] in Specimen by Rapid immunoassay
- HIV 1+2 Ab+HIV1 p24 Ag [Presence] in Serum or Plasma by Immunoassay
- HIV 1+2 RNA [Presence] in Serum or Plasma by NAA with probe detection

5. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Name** in the subsequent textbox: *If other, please specify.*

Test Name* ?

Other

If other, please specify.* ?

6. Select the **Common Brand/Test Kit Name** from the dropdown menu.

Test Name* ?

HIV 1+2 Ab [Presence] in Serum, Plasma or Blood by Rapid immunoassay

If other, please specify. ?

Common Brand/Test Kit Name*

Select...

- HIV 1/2 STAT-PAK Assay
- INSTI HIV-1/HIV-2 Antibody Test
- Sure Check HIV 1/2 Assay

- 7. Select the **appropriate answer** from the dropdown menu for the field: *Is this a point of care (POC) test?*

Is this a point of care (POC) test?

Select...

- No
- Unknown
- Yes

- 8. If applicable, enter the **EHE/KY Evaluation Web Number** in the textbox.
- 9. If applicable, enter the **Filler Order/Accession Number** in the textbox.

EHE/KY/Evaluation Web Number ?

Filler Order/Accession Number ?

- 10. Select the appropriate **Specimen Source** from the *Specimen Source* dropdown menu.

Specimen Source*

Select...

- Abscess
- Amniotic fluid
- Aspirate
- Bile fluid
- Blood
- Blood (arterial)
- Blood (capillary)

- 11. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Specimen Source** in the subsequent textbox: *If other, please specify.*

Specimen Source*

Other

If other, please specify.* ?

12. Select the **appropriate Test Result** from the *Test Result* dropdown menu.

13. If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Result** in the subsequent textbox: *If other, please specify.*

14. Enter the **Test Result Date**.

15. Enter the **Specimen Collection Date**.

Please Note: The Specimen Collection Date cannot occur **after** the Test Result Date. The Specimen Collection Date must occur on the **same date** or any date **BEFORE** the Test Result Date. If you enter a Specimen Collection Date that occurs **after** the Test Result Date, both fields are marked as invalid.

If you click **Next**, the **Laboratory Information** screen displays an error banner with a message that states: *There are errors. Please make a selection for all required fields.*

To proceed, you must enter a valid Specimen Collection Date that occurs **on** or **before** the Test Result Date.

16. If applicable, enter **additional notes about the lab tests** in the *Additional Information* textbox.

Adding Multiple Tests

17. Click **Add Test** to log the details for multiple tests. This means that you can easily enter additional test details on the same patient.

Please Note: When you click the **Add Test** button, at least one lab test section must be entered.

- To delete an additional lab test section, click the **Trash Bin Icon** located at the top right.

18. Once the **Laboratory Information** screen is complete, click **Next** to proceed to the **Applicable Symptoms** screen.

16 Pediatric Applicable Symptoms

Perinatal HIV Exposure Applicable Symptoms

1. If **Perinatal HIV exposure** is selected on the **Birth History** screen, the **Applicable Symptoms** screen will display the following message at the top: *Applicable symptoms information is required only for Pediatric HIV cases. No information is required on this screen for Perinatal HIV cases. Please click the "Next" button to proceed.*

Applicable symptoms information is required only for Pediatric HIV cases. No information is required on this screen for Perinatal HIV cases. Please click the "Next" button to proceed.

APPLICABLE SYMPTOMS

Patient Information Were symptoms present during the course of illness?

Birth History Yes No Unknown

Please specify if this form is being completed for a perinatal HIV exposure or pediatric HIV/AIDS case.*

Perinatal HIV exposure x v

2. Click **Next** to proceed to the **Additional Comments** screen.

Save Previous **Next**

Pediatric HIV/AIDS Case Applicable Symptoms

3. If **Pediatric HIV/AIDS case** is selected on the **Birth History** screen, the **Applicable Symptoms** is enabled. Select the **appropriate answer** for the conditional question at the top: *Were symptoms present during the course of illness?*

APPLICABLE SYMPTOMS

Patient Information Were symptoms present during the course of illness?*

Birth History Yes No Unknown

4. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled.

APPLICABLE SYMPTOMS

Patient Information Were symptoms present during the course of illness?*

Birth History Yes No Unknown

Laboratory Information

Applicable Symptoms

Additional Information Onset Date* Unknown

Hospitalization, ICU, & Death Information If symptomatic, which of the following did the patient experience during illness?

Vaccination History Fever* Yes No Unknown

Service Referrals If yes, please enter the highest temperature.

Treatment Information

Please Note: If **No** is selected for the conditional question, all subsequent symptom fields are disabled and marked with **No**. If **Unknown** is selected for the conditional question, all subsequent symptom fields are disabled and marked as **Unknown**.

- 5. Enter the **Onset Date** for the symptoms. If the onset date is unknown, click the **Unknown** checkbox.

Onset Date* ?
mm/dd/yyyy Unknown
May 2024
Su Mo Tu We Th Fr Sa
28 29 30 1 2 3 4
5 6 7 8 9 10 11
12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30 31 1
How did the patient experience during illness?
Unknown
temperature. ?
period)*

- 6. To report whether the patient had a fever during the illness, select the **appropriate answer** for the field: *Fever*.

If symptomatic, which of the following did the patient experience during illness?
Fever*
Yes No Unknown
If yes, please enter the highest temperature. ?

- 7. If **Yes** is selected, the subsequent field is enabled. Enter the **patient's highest temperature** in the subsequent textbox: *If yes, please enter the highest temperature.*

Fever*
Yes No Unknown
If yes, please enter the highest temperature.* ?

- 8. To report the patient had diarrhea during the illness, select the **appropriate answer** for the field: *Diarrhea (>3 loose stools/24hr period).*

Diarrhea (>3 loose stools/24hr period)*
Yes No Unknown
If yes, please enter the number of days with diarrhea. ?

- 9. If **Yes** is selected, the subsequent field is enabled. Enter the **number of days with diarrhea** in the subsequent textbox: *If yes, please enter the number of days with diarrhea.*

Diarrhea (>3 loose stools/24hr period)*

If yes, please enter the number of days with diarrhea.* ?

- 10. Select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Chills*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>	Myalgia*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Lymphadenopathy*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>	Night sweats*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Malaise*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>	Pharyngitis*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Mouth ulcers*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>	Rash*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>

- 11. To report additional symptoms not listed on the screen, select the **appropriate answer** for the field: *Did the patient have any other symptoms?*

Did the patient have any other symptoms?*

- 12. If **Yes** is selected, the subsequent field is enabled. Enter the **patient's other symptoms** in the subsequent textbox: *If yes, please specify.*

- 13. Once complete, click **Next** to proceed to the **Additional Information** screen.

Did the patient have any other symptoms?*

If yes, please specify.* ?

17 Pediatric HIV Additional Information

1. On the **Additional Information** screen, the following question displays at the top of the screen: *After 1977 and before the earliest known diagnosis of HIV infection, has the child's birthing person had any of the following?* Select the **appropriate answers** for the following fields:

- *Perinatally acquired HIV infection*
- *Injected nonprescription drugs*

After 1977 and before the earliest known diagnosis of HIV infection, has the child's birthing person had any of the following?

Perinatally acquired HIV infection*

Yes	No	Unknown
-----	----	---------

Injected nonprescription drugs*

Yes	No	Unknown
-----	----	---------

2. The **Additional Information** screen displays the following question: *Has the birthing person had heterosexual relations with any of the following?* Select the **appropriate answers** for the following fields:

- *Heterosexual contact with intravenous/injection drug user*
- *Heterosexual contact with bisexual male*
- *Heterosexual contact with person with hemophilia/coagulation disorder with documented HIV infection*
- *Heterosexual contact with transfusion recipient with documented HIV infection*
- *Heterosexual contact with transplant recipient with documented HIV infection*
- *Heterosexual contact with person with documented HIV infection, risk not specified*

Has the patient had any heterosexual relations with any of the following?

Heterosexual contact with intravenous/injection drug user*

Yes	No	Unknown
-----	----	---------

Heterosexual contact with bisexual male*

Yes	No	Unknown
-----	----	---------

Heterosexual contact with person with hemophilia/coagulation disorder with documented HIV infection*

Yes	No	Unknown
-----	----	---------

Heterosexual contact with transfusion recipient with documented HIV infection*

Yes	No	Unknown
-----	----	---------

Heterosexual contact with transplant recipient with documented HIV infection*

Yes	No	Unknown
-----	----	---------

Heterosexual contact with person with documented HIV infection, risk not specified*

Yes	No	Unknown
-----	----	---------

Please Note: Some fields may be disabled based on the User's selections on the **Patient Information** screen for the field: *What is the patient's sexual orientation?*

- 3. Select the **appropriate answer** for the conditional question: *Has the birthing person received a transfusion of blood/blood components (other than clotting factor)?*

Has the birthing person received a transfusion of blood/blood components (other than clotting factor)?*

Yes No Unknown

If yes, please specify the reason for the transfusion.

0/300 Characters

First Received Date: Unknown

Last Received Date: Unknown

- 4. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.
- 5. Enter the **reason for the transfusion** in the textbox for the field: *If yes, please specify the reason for the transfusion.*
- 6. Enter the **First Received Date** and **Last Received Date**. If the first received date or last received date are unknown, click the **Unknown** checkbox.

Has the birthing person received a transfusion of blood/blood components (other than clotting factor)?*

Yes No Unknown

If yes, please specify the reason for the transfusion.*

0/300 Characters

First Received Date*: Unknown

Last Received Date*: Unknown

- 7. Select the **appropriate answer** for the field: *Has the birthing person received a transplant of tissue/organs or artificial insemination?*

Has the birthing person received a transplant of tissue/organs or artificial insemination?*

Yes No Unknown

Before the Diagnosis of HIV Infection

- 8. The **Additional Information** screen captures details about the patient before the diagnosis before HIV infection. Fields may be disabled if the Users indicated the form is being completed for **Perinatal HIV exposure** on the **Birth History** screen.

Before the diagnosis of HIV infection, has the child had any of the following?

Injected nonprescription drugs

Received clotting factor for hemophilia/coagulation disorder

If yes, please specify the clotting factor that the child received.
Select...

If other, please specify.

Date Received
mm/dd/yyyy Unknown

Received a transfusion of blood/blood components (other than clotting factor)

If yes, please specify the reason for the transfusion.

0/300 Characters

First Received Date
mm/dd/yyyy Unknown

Last Received Date
mm/dd/yyyy Unknown

Received a transplant of tissue/organs

Sexual contact with a male

Sexual contact with a female

Has the child ever taken prophylaxis for Pneumocystis pneumonia (PCP)?

Date of First Use
mm/dd/yyyy Unknown

Date of Last Use
mm/dd/yyyy Unknown

Please specify if this form is being completed for a perinatal HIV exposure or pediatric HIV/AIDS case.*

9. If **Pediatric HIV/AIDS case** is selected on the **Birth History** screen, the following question is enabled on the **Additional Information** screen: *Before the diagnosis of HIV infection, has the child had any of the following?* Select the **appropriate answers** for the following fields:

- *Injected nonprescription drugs*
- *Received clotting factor for hemophilia/coagulation disorder*

Before the diagnosis of HIV infection, has the child had any of the following?

Injected nonprescription drugs*

Yes	No	Unknown
-----	----	---------

Received clotting factor for hemophilia/coagulation disorder *

Yes	No	Unknown
-----	----	---------

10. If **Yes** is selected for the *Received clotting factor for hemophilia/coagulation disorder* field, select the **appropriate answer** from the dropdown menu for the field: *If yes, please specify the clotting factor that the child received.*

Received clotting factor for hemophilia/coagulation disorder *

If yes, please specify the clotting factor that the child received.*

Select...

- DIC
- Factor 1
- Factor 2
- Factor 3
- Factor 4
- Factor 5
- Factor 6

11. If **Other** is selected, enter the **other clotting factor the child received** in the textbox for the field: *If other, please specify.*

If yes, please specify the clotting factor that the child received.*

Other

If other, please specify.*

12. Enter the **Date Received**. If the date received is unknown, click the **Unknown** checkbox.

Date Received*

mm/dd/yyyy Unknown

13. Select the **appropriate answer** for the conditional question: *Received a transfusion of blood/blood components (other than clotting factor).*

Received a transfusion of blood/blood components (other than clotting factor)*

Yes No Unknown

If yes, please specify the reason for the transfusion.

0/300 Characters

First Received Date Unknown Last Received Date Unknown

14. If **Yes** is selected, enter the **reason for the transfusion** in the textbox for the field: *If yes, please specify the reason for the transfusion.*

15. Enter the **First Received Date** and **Last Received Date**. If the first received date or last received date are unknown, click the **Unknown** checkbox.

Received a transfusion of blood/blood components (other than clotting factor)*

Yes No Unknown

If yes, please specify the reason for the transfusion.*

0/300 Characters

First Received Date* Unknown Last Received Date* Unknown

16. Select the **appropriate answers** for the following fields:

- *Received a transplant of tissue/organs*
- *Sexual contact with a male*
- *Sexual contact with a female*

Received a transplant of tissue/organs*

Yes No Unknown

Sexual contact with a male*

Yes No Unknown

Sexual contact with a female*

Yes No Unknown

17. Select the **appropriate answer** for the conditional question: *Has the child ever taken prophylaxis for Pneumocystis pneumonia (PCP)?*

Has the child ever taken prophylaxis for Pneumocystis pneumonia (PCP)?*

Yes No Unknown

Date of First Use Unknown Date of Last Use Unknown

18. If **Yes** is selected, enter the **Date of First Use** and **Date of Last Use**. If the date of first use or date of last use are unknown, click the respective **Unknown** checkbox.

Has the child ever taken prophylaxis for Pneumocystis pneumonia (PCP)?*

Date of First Use*

Unknown

Date of Last Use*

Unknown

Please Note: From this point forward, the subsequent fields will be enabled regardless of whether the User selected **Perinatal HIV exposure** or **Pediatric HIV/AIDS case** on the **Birth History** screen.

19. Select the **appropriate answers** for the following fields:

- Was the child breastfed/chestfed?
- Did the child receive premasticated/pre-chewed food from the birthing person?

Was the child breastfed/chestfed?*

Did the child receive premasticated/pre-chewed food from the birthing person?*

20. Select the **appropriate answer** from the dropdown menu for the field: *Who is the child's primary caretaker?*

Who is the child's primary caretaker?*

Select...

- Biological parent
- Foster/adoptive parent, relative
- Foster/adoptive parent, unrelated
- Other relative
- Social service agency
- Unknown
- Other

21. If **Other** is selected, enter the **child's other primary caretaker** in the textbox for the field: *If other, please specify.*

Who is the child's primary caretaker?*

Other

If other, please specify.*

- 22. If applicable, enter the **details for any other documented risk(s)** in the textbox for the field:
Please include other documented risk(s), if applicable.
- 23. Once complete, click **Next** to proceed to the **Hospitalization, ICU, & Death Information** screen.

Please include other documented risk(s), if applicable.

0/500 Characters

18 Pediatric HIV Hospitalization, ICU, & Death Information

- 1. On the **Hospitalization, ICU, & Death Information** screen, complete the same workflow listed in **Chapter 7 – Adult HIV Hospitalization, ICU, & Death Information**
- 2. Once complete, click **Next** to proceed to the **Vaccination History** screen.

- Patient Information ✔
- Birth History ✔
- Laboratory Information ✔
- Applicable Symptoms ✔
- Additional Information ✔
- Hospitalization, ICU, & Death Information ✔
- Vaccination History ✔
- Service Referrals ✔
- Treatment Information ✔
- Additional Comments ✔
- Review & Submit

Was the patient hospitalized?*

If yes, please specify the hospital name.*

Admission Date* Unknown Discharge Date* Unknown

Still hospitalized

Was the patient admitted to an intensive care unit (ICU)?*

Admission Date to ICU Unknown Discharge Date from ICU Unknown

Still in ICU

Did the patient die as a result of this illness?*

If yes, please provide the date of death.

Date of Death

19 Pediatric HIV Vaccination History

1. On the **Vaccination History** screen, the following message displays at the top: **NOTE: No additional information is required on this screen. Please click the "Next" button to proceed.**
2. Click **Next** to proceed to the **Service Referrals** screen.

20 Pediatric HIV Service Referrals

1. On the **Service Referrals** screen, complete the same workflow listed in **Chapter 9 – Adult HIV Service Referrals**
2. Once complete, click **Next** to proceed to the **Treatment Information** screen.

21 Pediatric HIV Treatment Information

1. On the **Treatment Information** screen, complete the same workflow listed in **Chapter 10 – Adult HIV Treatment Information**
2. Once complete, click **Next** to proceed to the **Treatment Information** screen.

TREATMENT INFORMATION

Has the patient been prescribed any antiretroviral (ARV) medications?^{2*}

Is the patient currently adhering to the prescribed medication regimen?^{2*}

Treatment Information

Treatment Start Date*
mm/dd/yyyy Unknown

Last Received Date*²
mm/dd/yyyy Unknown

Ongoing Treatment

Medication*²
Select... | v
If other, please specify.

Reason for Treatment*
Select... | v
If other, please specify.

Additional Information²
0/300 Characters

+ Add Treatment

Save Previous **Next**

22 Pediatric HIV Additional Comments

1. On the **Additional Comments** screen, complete the same workflow listed in **Chapter 11 – Adult HIV Additional Comments**
2. Once complete, click **Next** to proceed to the **Review and Submit** screen.

ADDITIONAL COMMENTS

Has the patient been diagnosed with an opportunistic illness since the onset of HIV symptoms or concurrent with HIV diagnosis?*

Opportunistic illness

Please specify the opportunistic illness.*

Select... | v

If other, please specify.

Date of Diagnosis* ⓘ

mm/dd/yyyy

+ Add Opportunistic illness

Please include additional comments or notes, if applicable.

0/1000 Characters

23 Pediatric HIV Review and Submit

1. On the **Review and Submit** screen, review the summary of information you have entered. Click the **appropriate section header** to make edits to the section’s information.

REVIEW & SUBMIT

Print Download

Patient Information

Disease/Organism	Date of Diagnosis	
Pediatric HIV	Unknown	
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?		
Yes		
Patient ID (MRN)	Affiliation/Organization	
PA1235654	Atrium Health	
Person Completing Form	Affiliation/Organization	
Miss Jane Doe (jane@mailinator.com)	Atrium Health	
Attending Physician/Clinician	Affiliation/Organization	
Dr. Fraiser McGill (fraisermcgill@email.com)	Atrium Health	
First Name	Last Name	
John	Doe	
Date of Birth		
2022/11/29		
Patient Sex	Ethnicity	Race
Female	Not Hispanic or Latino	Asked but Unknown

2. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Pediatric HIV Case Report Entry.

Additional Comments

Previous **Submit**

3. All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.

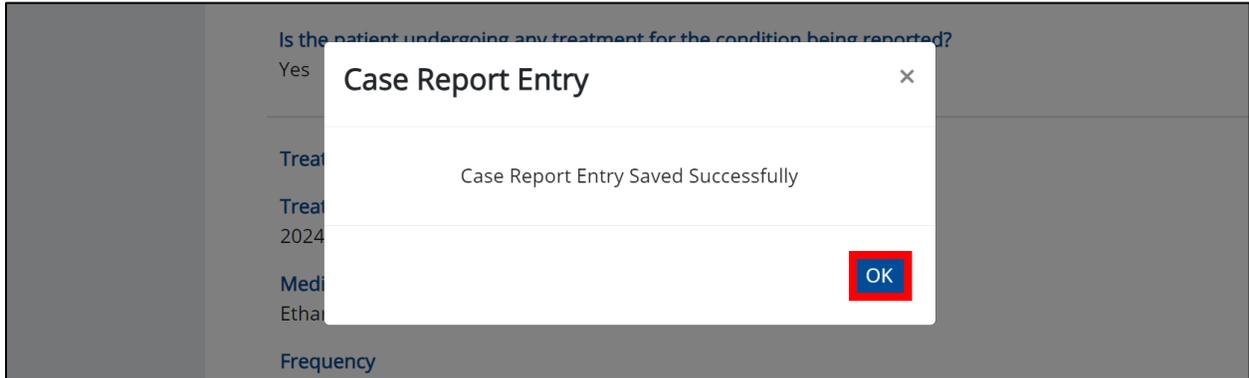
Case Report Entry

All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.

Cancel **Submit**

Please Note: Once a case report has been submitted, it is final. Should you later discover that you have entered inaccurate information, please use the **Support Tab** in the ePartnerViewer to report this information.

4. Click **OK** to acknowledge the case report has been submitted successfully.



Please Note: Clicking **OK** when the case report entry has been submitted successfully will automatically navigate you to the **Case Report Entry User Summary** screen.

Congratulations! You have submitted the Human Immunodeficiency Virus (HIV) Case Report using KHIE's Direct Data Entry functionality.

Please visit the KHIE website at <https://khie.ky.gov/Public-Health/Pages/Direct-Lab.aspx> to access additional training resources and find information on reporting requirements from the Kentucky Department for Public Health.

24 Technical Support

Toll-Free Telephone Support

For questions and assistance regarding the ePartnerViewer, please call 1 (800) 633-6283.

Email Support

To submit questions or request support regarding the ePartnerViewer, please email KHIESupport@ky.gov.

Please Note: To seek assistance or log issues, you can use the **Support Tab** located in the blue navigation bar at the top of the screen in the ePartnerViewer.

