



HIV Infection Notification Form

Pursuant to **WA Public Health Act 2016**
Notify within 72 hours to:

Director
Communicable Disease Control Directorate
PO Box 8172, Perth Business Centre WA 6849
Phone 08 9222 0255 or Fax 08 9222 0254

Notifier details

Name
Hospital/Clinic
Address
Suburb/Town Postcode
Telephone
Signature Date / /
dd / mm / yyyy

Notification details

New diagnosis: first notification in WA
 Diagnosed elsewhere: first notification in WA
If 'elsewhere', please specify date of diagnosis, place of diagnosis and source of information
Date / / Place
Source (Tick one or more) Doctor Laboratory Patient

Patient details

Family name
Given name
Street address
Suburb/Town Postcode
Date of birth / /
Sex Male Female Transgender

Is the patient of Aboriginal or Torres Strait Islander origin?

No Yes, Aboriginal Yes, Torres Strait Islander
For persons of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes

Country of birth Australia
 Other (Specify)

If 'Other', year of arrival in Australia

Language mostly spoken at home

English
 Other (Specify)

Residency Status

Resident of WA
 Resident of other State/Territory (Specify)
 Overseas student (Specify country)
 Other (Specify country and visa category)

Occupation (Tick one or more)

Sex worker
 Healthcare worker (Specify)
 Other (Specify)

Follow up (Tick one or more)

Patient/carer aware of diagnosis and that it is a notifiable disease
 Risk to contacts discussed with patient
 Patient has been referred to clinic (Specify)

Contact tracing (Tick one or more)

Contact tracing has been/will be coordinated by me
 Patient has been referred for contact tracing (Specify)
 Contact tracing assistance required
 Diagnosed elsewhere and further contact tracing not required

Reason for HIV test (Tick one or more)

Investigation of clinical symptoms suggestive of HIV infection
 Risk behaviour with HIV-infected person
 Other high risk behaviour (e.g. injecting drug use, unsafe sex)
 Named as a contact of HIV-infected person
 STI screening (Specify) Asymptomatic Symptomatic
 Other screening PrEP Antenatal Immigration
 Confirmation of a previous diagnosis of HIV infection
 Other (Specify)

Clinical status (Tick one)

Clinical status at time of specimen collection for this HIV notification

Asymptomatic
 Symptoms consistent with HIV seroconversion illness*
 Other symptoms of HIV infection (Specify)
 AIDS defining illness (Complete **AIDS** section overleaf)
 Deceased (Complete **Death** section overleaf)

Does the patient have a history of symptoms consistent with a seroconversion illness?*

Yes No Unknown
If 'Yes', specify date of symptoms / /

Treatment details

Is the patient currently on antiretroviral treatment?
 Yes No Unknown
If 'Yes', specify month/year commenced therapy /

Laboratory testing details

HIV type** HIV-1 HIV-2 HIV-1 & HIV-2
Date of first confirmed HIV test in WA / /

Laboratory evidence of newly acquired HIV infection**

Yes No Unknown
If 'Yes', specify test

Has the patient had a previous negative HIV test?

Yes No Unknown
If 'Yes', specify date of last negative test / /

Specify source of information on date of negative HIV test

Doctor Laboratory Patient

CD4+ count closest to time of HIV diagnosis cells/ μ l

Specify date of CD4+ cell count / /

Viral load closest to time of HIV diagnosis copies/ml

Specify date of viral load / /

* Seroconversion illness occurring 2-4 weeks following exposure to HIV, characterised by fever, lethargy, anorexia, pharyngitis, headache, myalgia, arthralgia and/or lymphadenopathy
** HIV subtype, HIV resistance genotype and indication of recent infection (BED immunoassay) will be collected periodically from HIV Reference Laboratories

HIV risk factors

Please indicate the patient's reported risk factors by ticking the appropriate boxes below.

1. Sexual exposure (Tick one)

- Sexual contact with person(s) of same sex only (Go to 2.)
- Sexual contact with both sexes (Go to 2.)
- Sexual contact with person(s) of opposite sex only (Go to 3.)
- No sexual contact (Go to 5.)
- Sexual exposure not known (Go to 5.)

2. Men who have sex with men

From whom was this infection most likely acquired? (Tick one)

- Regular partner
- Casual partner
- Unknown

How did the patient meet their likely source partner(s)?

(Tick one or more)

- Smart phone app (e.g. Grindr)
- At a sex on premises venue (e.g. sauna)
- At a 'beat' or other public place (e.g. public toilet)
- Other (Specify)

3. Heterosexual exposure (Tick one or more)

What was the exposure history of sexual partner(s)?

- Man who has had sex with men
- Injecting drug user
- Recipient of blood/blood products/tissue
- Person with haemophilia/coagulation disorder
- Person from a country other than Australia (Specify country)

Date of most recent heterosexual contact with such person(s)

...../...../.....

Did heterosexual contact with such person(s) occur in Australia?

- Yes No Not reported
- Person with diagnosed HIV infection (Specify person's exposure)

Heterosexual contact, not further specified

4. Has the patient had sex under the influence of drugs?

- Yes (Specify) No Unknown
- (e.g. cannabis, crystal meth, ecstasy, amphetamines, etc.)

5. Blood exposure (Tick one or more)

- Injecting drug user
- Recipient of blood, blood products or tissue (Specify)
- Haemophilia/coagulation disorder
- Needle stick/splash

6. Mother-to-child transmission

- Mother-to-child transmission (Specify mother's exposure)

7. Other or undetermined source of exposure

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Place of acquisition of HIV infection

Most likely place of acquiring infection (Specify state/country)

If overseas, specify reason for being in that country
(e.g. work, holiday, born in country, refugee, visiting family)

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Blood/Tissue donations prior to diagnosis

Has your patient donated blood or other body fluid/tissue prior to HIV diagnosis?

- Yes No Unknown

If 'Yes', contact Australian Red Cross Blood Service (Tel: 1300 669 054)

AIDS defining illness

Does the patient currently have AIDS?

- Yes No Unknown

Date of AIDS diagnosis in WA/...../.....

If diagnosed elsewhere, please specify date and place of diagnosis

Date/...../..... Place

Diseases indicative of AIDS (Tick one or more)

Definite Probable

- Pneumocystis jiroveci (carinii)* pneumonia
- Oesophageal candidiasis
- Kaposi's sarcoma (Site)
- Herpes simplex virus of >1 month duration
(Site)
- Cryptococcosis (Site)
- Cryptosporidiosis (diarrhoea > 1 month)
- Toxoplasmosis (Site)
- Cytomegalovirus (Site)
- Mycobacterium tuberculosis* complex
 Pulmonary Extrapulmonary
- A typical mycobacterial disease
Type Site
- Lymphoma
Type Site
- HIV encephalopathy
- HIV wasting syndrome
- Invasive cervical cancer
- Recurrent pneumonia (2 or more episodes in 1 year)
- Other (Specify)

Death with HIV infection

Date of death/...../.....

Was the death AIDS-related? Yes No

Specify cause of death

Further comments

If you require assistance with the public health management of your patient, please phone 08 9222 0255.

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