



# NOTIFICATION OF HIV INFECTION OR DEATH OF A PERSON WITH HIV INFECTION

<b>NSW HIV Number:</b>	<b>Doctor Name:</b>
<b>Family name</b> (first two letters only)	<b>Clinic Name:</b>
<b>Given name</b> (first two letters only)	<b>Clinic patient code:</b>
<b>Date of birth:</b>	<b>Date first positive in NSW:</b>
<b>Gender:</b> Male    Female    Transgender	<b>Date form sent out:</b>

**Question 1.** Is this patient in your care for HIV infection?    YES; go to Question 3    NO; go to Question 2

**Question 2.** The patient is not in my care for HIV infection because the patient:

(select all that apply and then continue to complete the rest of the form as best you can):

was referred on date: \_\_\_\_\_, to Dr \_\_\_\_\_

Tel: \_\_\_\_\_, Address: \_\_\_\_\_

was lost to follow up, due to:

was hospitalised on date: \_\_\_\_\_, in (name of hospital): \_\_\_\_\_

died on date: \_\_\_\_\_, due to:

other reason (*specify*): \_\_\_\_\_

**Question 3.** For this patient please provide the most recent:

Consultation date: \_\_\_\_\_

CD4 count: \_\_\_\_\_, specimen date: \_\_\_\_\_

Viral load: \_\_\_\_\_, specimen date: \_\_\_\_\_

**Question 4.** Has this patient commenced antiretroviral therapy (ART)?

YES, on date: \_\_\_\_\_

NO, due to:    Patient not ready (*specify*): \_\_\_\_\_

                  Patient declined ART (*specify*): \_\_\_\_\_

                  Not clinically indicated (*specify*): \_\_\_\_\_

                  Other reason (*specify*): \_\_\_\_\_

**Question 5a.** How many contacts were identified? \_\_\_\_\_

**5b.** How many were reached by i) the patient: \_\_\_\_\_

                  ii) your service: \_\_\_\_\_

                  iii) another service: \_\_\_\_\_

                  (*specify*): \_\_\_\_\_

**Question 6.** Please complete/update: HIV subtype (e.g. B or CRF01\_AE): \_\_\_\_\_

**Question 7.** Country this HIV infection was most likely acquired: \_\_\_\_\_

**Question 8.** Other questions for the doctor: \_\_\_\_\_

                  Answers to Question 8. \_\_\_\_\_

**Question 9.** Additional comments: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return completed HIV enhanced surveillance forms to the HIV Surveillance Officer either by:

1. Post: Communicable Diseases Branch, NSW Health, Locked Bag 2030 ST LEONARDS NSW 1590.

2. Secure fax: Communicable Diseases Branch, NSW Health, Fax. 02 9391 9189.

For enquires please call 02 9391 9195 or email [NSWH-HIV@health.nsw.gov.au](mailto:NSWH-HIV@health.nsw.gov.au)