DIS Number ☐ # HIV INTERVIEW RECORD Case ID ☐

Testing and Treatment History

Date Survey Completed: ☐☐-☐☐-☐☐ (mm/dd/yy) | **Name:**

1. When was the **FIRST** time you ever tested **POSITIVE** for HIV? ☐☐-☐☐ (mm/yy)
   Date of Positive (DOP)

2. When was the **FIRST** time you **EVER** got an HIV test?
   (whether positive or negative) ☐☐-☐☐

3. Have you **EVER** had a test that was **NEGATIVE?** ☐ Y/N/R/D

   If yes, when did you get your **LAST NEGATIVE?** ☐☐-☐☐

4. Was your **VISIT** from your first positive test on ☐☐-☐☐ (DOP): Circle one

Inpatient:

Hospital, Drug Treatment, Hospice, **Other:**_____

Outpatient:

Private Doctor, Community Health Clinic, Health Dept, Blood Donation, **Other:**_____

5. What was your **REASON** for getting the test on ☐☐-☐☐ (DOP) - Check one:

- ☐ Patient has symptoms, recent illness, wt loss, OI
- ☐ Current STD and/or STD screening
- ☐ Blood/plasma donation or referred by blood bank
- ☐ Hospitalization, pre-op test, other procedure
- ☐ Needed to initiate care
- ☐ Required by Military, Insurance or other agency
- ☐ Community screening /free test /test offered
- ☐ Named as contact to a partner/ex who is HIV+
- ☐ MD recommendation / rule out HIV diagnosis
- ☐ Incarceration
- ☐ Prenatal screening or pregnancy
- ☐ Entry to drug/alcohol treatment
- ☐ Because you regularly test (i.e. every 6 months)
- ☐ **Other:** _____

6. In the **2 YEARS before** ☐☐-☐☐ (DOP), how many times did you have an HIV test? 1+ **Tests?**

7. In the **6 MONTHS before** ☐☐-☐☐ (DOP), were you taking any of these HIV Medications? ☐ Y/N/R/D

   If yes, **which** medications did you take: _____ _____ _____

   Are you taking any of these medications **now?**

   When was the **first** ☐☐-☐☐-☐☐ and **last** ☐☐-☐☐-☐☐ day you took these medications?

HIV and TB

8. Has the patient been **medically evaluated** for HIV infection by a physician? ☐ Y/N/R/D

   If yes, the **Physician's** name: _____ Phone: _____

   If no, has the patient's been **referred** for HIV disease case management?

Case manager's name: _____ Date: ☐☐-☐☐-☐☐

Y – Yes N – No R – Refused to Answer D – Did not ask

Case ID _____

9. Is the patient a blood product **donor**? ☐ Y/N/R/D

If yes, dates: ▓▓ - ▓▓ - ▓▓ Facility Name: _____

10. Date of **HIV test** from FIELD RECORD: ▓▓ - ▓▓ - ▓▓ Site : _____ Result: _____

Date of **Repeat Test**: ▓▓ - ▓▓ - ▓▓ State Site: _____ Result: _____

Refused? : _____

11. Date of TB Skin Test: ▓▓ - ▓▓ - ▓▓ State Site: _____ Refused? : _____

Has the patient been diagnosed with **pulmonary** TB? ☐ Y/N/R/D

Has the patient been diagnosed with **extra-pulmonary** TB? ☐ Y/N/R/D

Has the patient been referred in-house for TB skin test, flu pneumonia **immunizations**? ☐ Y/N/R/D

Sexually Active Females

12. Has the patient been referred to a **family planning** clinic? ☐ Y/N/R/D

13. Has the patient ever **delivered** a live-born infant? ☐ Y/N/R/D

If yes, when was the most **recent birth**? ▓▓ - ▓▓ - ▓▓

14. Is the patient **Pregnant**? ☐ Y/N/R/D

If yes, has she been referred for **prenatal care**? Due Date ▓▓ - ▓▓ - ▓▓

Risk Factors

15. Has the patient had more than one **sex partner** during his/her lifetime? ☐ Y/N/R/D

16. Has the patient received a **blood transfusion**? ☐ Y/N/R/D

If yes, Date: ▓▓ - ▓▓ - ▓▓ Facility: _____

17. Is the patient **hemophiliac**? ☐ Y/N/R/D

If yes, what **type**: _____

18. If patient is less than 13, is the **mother infected** with HIV/AIDS? ☐ Y/N/R/D

19. Is the patient Health Care Worker with history of **blood/body fluid** exposure? ☐ Y/N/R/D

20. Did the patient know that they were at **risk**? ☐ Y/N/R/D

21. Does the patient currently **attend** any type of **school**? ☐ Y/N/R/D

If yes, **Name**: _____

Y – Yes N – No R – Refused to Answer D – Did not ask

Case ID [ ]

Below is an official Mississippi State Department of Health document and is considered a legal document.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

I acknowledge that the six following requirements have been explained to me:	Initial:
Safer sex practices *(condoms, limiting the number of sexual partners, etc.)*	
Necessity of ***informing future contacts*** *of HIV positive status before sex or needle sharing activities (even if condoms are used)*	
Necessity of ***not donating*** *and/or* ***selling blood*** *or blood products*	
Necessity of not causing ***pregnancy*** *or becoming pregnant*	
Necessity of ***informing all health care providers*** *of HIV positive status when seeking health care*	
Quarantine *Order*	

PATIENT SIGNATURE:_____ ***DATE:***_____

MSDH SIGNATURE:_____ ***DATE:***_____

NOTES

_____

_____

_____

_____

_____

_____

HIV INTERVIEW
FORM No. 917

PURPOSE

This form is to be completed by the Disease Intervention Specialist (DIS) or Health Protection Nurse (HPN) upon notification of positive HIV status. It will also assure appropriate care process and related documentation needed for surveillance.

NOTE: THIS DOCUMENT CONTIANS VERY SENSITIVE AND PRIVATE INFORMATION ABOUT THE ORIGINAL PATIENT. IT SHALL BE HANDLED IN A CONFIDENTIAL MANNER AT ALL TIMES.

INSTRUCTIONS

- Last First - Enter the patient's last name in the first field labeled "Last" and the patient's first name in the field labeled "First".
- Date Survey Completed - Enter the date of the interview. If the patient is deceased, enter the date the interview was attempted and deceased status was obtained.
- HARS Number - Enter the HIV/AIDS Reporting System Number.
- DIS Number - Enter the Disease Intervention Specialist identification number. Leave blank if the HPN is completing the form.

1. When was the FIRST time you ever tested POSITIVE for HIV? This date will be referred to as the Date of Positive.

2. When was the very FIRST time you EVER had an HIV test? (Whether test was Positive or Negative)

3. Have you EVER had an HIV test that was NEGATIVE? (If no skip 3a)
   - If the patient indicates that he/she has had a Negative HIV test, Check "Y" for yes. If the patient has never had a negative test, check "N" for no and skip question 3a.
   - If the patient refuses to answer the question check "R" for refused and if the patient does not know if they ever had a negative test, check "D" for don't know.
   - If yes, when did you get your LAST NEGATIVE test?
   - Indicate Month and Year for the patient's last negative HIV test.

4. Was your VISIT from your first positive test on _/_(DOP): circle one INPATIENT/ OUTPATIENT?

   a. Ask the patient what type of visit prompted their first HIV positive test:
      1. INPATIENT (Hospital, ER, Hospice, and etc)
      2. OUTPATIENT (Community Clinic, Doctor's office, Health Dept STD Clinic
   b. What was the REASON for taking an HIV test on the Date of Positive?
   c. Ask and record the reason given for taking the test that had the first positive result.

5. In the two years before _/_ (DOP), how many times did you have an HIV test?
   The first box has entered "1" to account for the first positive. In the empty box, indicate the number of tests taken in the 2 years previous to the first positive. This also refers to cases where the Date of Positive is from years previous.

6. In the six months before _/_ (DOP), were you taking any HIV MEDICATIONS? (If no, skip to # 7).
   The question is meant to determine if the blood sample collected for ST ARHS analysis has been somehow altered due to the use of un-prescribed HIV medication (i.e., HIV medications given to the patient by a sexual partner or friend).

If the patient did not use HIV medications before receiving their first positive test, check N for no and proceed to question # 7.

If the patient did use HIV medications before receiving their first positive test, check Y for yes and proceed to the following four questions.

Note: Show the updated HIV Medication chart when asking this question to assist the patient in identification of any drugs they may have taken.

a. Which HIV Medications did you take? List the drugs by the name that appears in the HIV Medication Chart.

b. What was the first day you took these HIV medications? Record the first day of HIV medication use (should be previous to the Date of Positive).

c. Are you taking any of the HIV Medications now? Check Y for yes, N for no, R for refused or D for don't know.

d. When was the last day that you took these medications? Record the last day of HIV Medication use.

HIV and TB

7. Has the patient been medically evaluated for HIV infection by a physician? Check the appropriate box for answer.

   a. If yes, the physicians name/phone. If the answer to question 9 is yes, indicate the physician's name and phone number, if available, in the space provided.
   b. If no, has the patient been referred for HIV disease case management? Check the appropriate box for answer.
   c. To whom have you referred the patient for case management. (Case manager's name/phone). If the patient has been referred, indicate the case manager's name and date of referral in the space provided.

8. Is the patient a blood product donor? (includes plasma). Check the appropriate box for answer. If yes, enter the date and medical facility of any/all blood donations made by the original patient.

9. Date of HIV test from field record/Site name/Result.
   Enter the date, location of test and result of test in the space provided.

10. Date of repeat test (document refusal date, name of County Health Dept., and results). Check the appropriate box. Enter the date, county and results of the HIV repeat test.

11. Date of TB skin test (document refusal date and name of County Health Dept).
    Enter the date and county where the TB test was performed

    a. Has the patient been diagnosed with pulmonary TB? Check the appropriate box.
    b. Has the patient been diagnosed with extra-pulmonary TB? Check the appropriate box.
    c. Has the patient been referred in house for TB ski test, flu and pneumonia immunizations? Check the appropriate box.

Sexually Active Females

12. Has the patient been referred to a family planning clinic? Check the appropriate box.

13. Has the patient ever delivered a live-born infant? Check the appropriate box. a. If yes, when was the most recent birth? Enter the most recent date.

14. Is the patient pregnant? Check the appropriate box.

    a. If yes, has she been referred for prenatal care? Check the appropriate box
    b| Enter the due date and risk factors

15. Has the patient had more than one sex partner during his/her lifetime? Check the appropriate box.

16. Has the patient received a blood transfusion? Check the appropriate box. If yes, in the "Date" – "Facility" box enter the date(s) of transfusion and the medical facility on the space provided.

17. Is the patient a hemophiliac? Check the appropriate box. If yes, what type? Enter the type of hemophilia on the space provided.

18. If the patient is less than 13, is the mother infected with HIV/AIDS? Check the appropriate box if the patient's mother is infected with HIV/AIDS.

19. Is the patient a Health Care Worker with a history of blood/body fluid exposure?

20. Did the patient know that they were at risk? Check the appropriate box.

21. Does the patient currently attend any type of school? If yes, enter name of school.

Discussion

Items 1-6 should be discussed with patient and discussion indicted by entering initials.
After discussion of items 1-6, ask the patient to sign in the space provided to verify that the above six issues were read and explained to them. If patient refuses to sign form, the DIS or Epi Nurse conducting the interview should document this in the "Notes".

Signature of the Interviewer

Enter the complete and legible signature of MSDH employee and date in the space provided.

Notes:

Any additional information that may be pertinent to that case should be recorded in the note. Attach additional sheets if necessary.

OFFICE MECHANICS AND FILING

The field DIS/PHN conducts the HIV interview and completes the HIV Interview form. The completed form will be sent along with CDC's Interview Record #73.54 to the appropriate DIS Supervisor or Epi Nurse to be checked for completeness and correctness of information and then be initialed. The original or other legible copy is forwarded to the STD/HIV Bureau's Surveillance Branch for data entry. The Interview Record is to be copied and stored in a secure cabinet by the DIS Supervisor or Epi Nurse. The STD/HIV Office Surveillance Branch staff stores the original or other legible copy with the CDC Interview Record #150 and retain indefinitely.