



# CASE REPORT FORM

Under Section 74 of the Health Act 1956

FORM 1A: NOTICE OF CASE OF NOTIFIABLE DISEASE, NAMELY ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

## DISEASE NAME

ACQUIRED IMMUNODEFICIENCY SYNDROME

## NOTIFIER IDENTIFICATION

Name of reporting practitioner \_\_\_\_\_ Contact Phone (\_\_\_\_) \_\_\_\_\_

Date reported \_\_\_\_/\_\_\_\_/\_\_\_\_

## CASE IDENTIFICATION

DO NOT IDENTIFY THE PATIENT BY NAME OR ADDRESS

Instead, complete the boxes below with the first two (2) letters of the surname, first initial of given name, sex and date of birth. If name begins with "Mac", "Mc", "van der", etc. do not include these letters. (For example, a person called James McCallum born 2 June 1956 would appear as CAJM020656).

1 <sup>st</sup> two letters of surname	1 <sup>st</sup> initial of given name	Sex	Day	Month	Year

## CASE DEMOGRAPHY

DATE OF DIAGNOSIS: (in New Zealand or overseas) \_\_\_\_/\_\_\_\_/\_\_\_\_

DISTRICT OF USUAL RESIDENCE: \_\_\_\_\_

ETHNICITY: *Tick all that apply. Ask the patient.*

NZ Maori
  NZ European/Pakeha  
 Pacific Islands people
  Other European \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

MODE OF INFECTION: (More than one may be ticked)

- Homosexual behaviour
- Heterosexual behaviour (detail) \_\_\_\_\_
- Receipt transfusion/blood products
- Receipt coagulation factor
- Needle sharing between injecting drug users
- Congenital/perinatal (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Not known (detail) \_\_\_\_\_

SEROLOGY: *(Tick one)*

- HIV Antibody serology ' Positive
- ' Negative
- ' Not done

CLINICAL:

*(More than one may be ticked)*

- ' Opportunistic infection (specify type) \_\_\_\_\_
- ' Kaposi's sarcoma
- ' Invasive cervical cancer
- ' HIV encephalopathy including dementia
- ' Lymphoma
- ' Recurrent bacterial pneumonia

PRESENT STATUS

- ' Alive
- ' Dead *(Date of death)*
- ' Gone overseas
- ' Moved to *(Health District)* \_\_\_\_\_

SIGNATURE OF MEDICAL PRACTITIONER \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments:

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For Office Use:

SIGNATURE OF MEDICAL OFFICER OF HEALTH \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments:

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