Field Record

Last Name | First (& Nickname) — 1

Address (Street) (Apt. #) — 2

City, State, & Zip Code | Telephone Number

Age/D.O.B. / — 3

Race: AI/AN | A | B | [illegible] — 4 | W | U | R

Hispanic: Y | [illegible] — 5 | R

Gender: M | F | MTF | F[illegible] — 6 | U | R

Marital Status — 7: M | Sep | D | W | C | U | R

Internet Alias/E-mail Address — 8

Internet Site/System — 9

Height — 10 | Size/Build — 11 | Hair — 12 | Complexion — 13

Place of Employment/Hours/Phone — 14

Other Identifying, Locating, or Medical Information — 15

FR Number — 38 | OOJ No. — 39 | OOJ Area — 40 | Due Date / — 41

1

Patient Demographic Information

Ix Only FR: Yes ☐ — 16 ☐

Referral Basis:	Disease 1	Disease 2
☐ **Partner** _____		
☐ **S/A** _____ — 17		
☐ **Positive Lab Test**		
☐ **OOJ/ICCR** _____		

Pregnant? Y _____ W K s. [illegible] — 18 U

900 Case Status: — 19

Original Patient ID. Number: — 20

Exposure: First | Fr[illegible] — 21 | Last

Date	Test	Result	Provider

22

Date	Drugs	Dosage	Provider

23

Initiating Agency — 24 | Invest. Agency — 25 | Clinic Code — 26

2

Epidemiological/Medical Information

Disease 1

Interviewer Number: — 27

Date Initiated: / /

Type Interview: — 29 | Type Referral:

Dispo: — 31

Date: / /

New Case #: — 33

DX: | Worker: — 35

Disease 2

Interviewer Number:

Date Initiated: — 28 /

Type Interview: | Type Referral: — 30

Dispo:

Date: — 32 /

New Case #:

DX: — 34 | Worker:

Internet Outcome: — 36 | Post-test Counseled — 37

3

Investigation Outcomes

5

Documentation & Field Notes

60

4 900 Partner/Social Contact Information

900 PS Information **(Complete on all 900 Sexual Contacts)**

42 Interviewed? / 43 900 PS Interview Date

Sex at Birth: 44 additional, Specify: 45

Notifiability: 46 Plan: 47 Actual Method: 48

Self-Reported Results: 49

50 / Date of Last 900

Referral 1: 51 52 / Referral Date Test: 53 Result: 54

Post: 55 **900+ Only:** Referral 2: 56 First Appt.: 57

FACTORS **Optional for 900 negative sexual & social contacts, associates, or cohorts.**

58

	Y/O/U/N/R/D		Y/N/R/D
Male	☐	IDU	☐
Female	☐	Share Equipment	☐
Transgender	☐	NIR	☐
Condom	☐	Other	☐

Other (Specify): _____

Standard Documentation Abbreviations

Bic - Bicillin
C/B - Call back/Called back
CLIX - Cluster Interview
CX - Contact
CL - Cluster
CSW - Commercial Sex Worker
FB - Field Blood
FR - Field Record
FV - Field Visit
HX - History
IM - Intramuscular
IP - Index Patient
IX - Interview
LX – Lesion
MSM - Men who have Sex with Men
OI - Original Interview
OP - Original Patient
P/C - Phone Call
Pt - Patient
RI - Reinterview
RS - Record Search
SX - Symptoms
TX - Treatment
PTC - Post-test counsel
W/ - With
WBI - Will be in
W/O - Without

5 Documentation & Field Notes

59

Disease/Diagnosis (34)
030 - HepB acute w/o delta
031 - HepB acute w/ delta
033 - HepB chronic w/o delta
034 - HepB chronic w/ delta
042 - Hepatitis delta
051 - Hepatitis C, acute
053 - Hepatitis E
054 - Hepatitis C, chronic
070 - Hepatitis, unknown
100 - Chancroid
200 - Chlamydia
300 - Gonorrhea (uncomplicated)
350 - Resistant Gonorrhea
400 - Non-Gonoccocal Urethritis (NGU)
450 - Mucopurulent Cervicitis (MPC)
490 - PID Syndrome
500 - Granuloma Inguinale
600 - Lymphogranuloma Venereum (LGV)
710 - Syphilis, primary
720 - Syphilis, secondary
730 - Syphilis, early latent
740 - Syphilis, unknown duration
745 - Syphilis, late latent
750 - Syphilis, late w/ symptom
790 – Syphilis, congemital
800 - Genital Warts
850 - Herpes
900 - HIV Infection
950 - AIDS (Syndrome)
951 - Recounsel for previous AIDS case

Race (4)
AI/AN - American Indian or Alaskan Native
A - Asian
B - Black or African American
NH/PI - Native Hawaiian or Other Pacific Islander
W - White
U - Unknown
R - Refused to Answer

Gender (6)
M - Male
F - Female
MTF - Male to Female Transgender (44)
FTM - Female to Male Transgender
U - Unknown
R - Refused to Answer

Marital Status (7)
S - Single, Never Married
M - Married
SEP - Separated
D - Divorced
W - Widowed
C - Cohabitation
U - Unknown
R - Refused to Answer

Sexual Risk Factors (58)
Y-Yes, Anal or Vaginal Intercourse (with or without Oral Sex)
O-Yes, Oral Sex Only
U-Unspecified Type of Sex
N-No
R-Refused to Answer
D-Did Not Ask

Non-Sexual Risk Factors (58)
Y – Yes **N** – No
R – Refused **D** – Did Not Ask

Referral Basis (17)
T1 - Positive Test Result
T2 - Case Report
T3 - Clinic Walk-In
T4 – Second Positive Test
F1 - Congenital Follow-Up
F2 - 900 Re-Counsel
F3 - Test of Cure
F4 - Treatment Restart
F5 - Treatment Only
F6 - Vaccination
M1 - Maternal Follow-up
M2 - Infant Follow-up
P1 - Sex Partner
P2 - Needlesharing Partner
P3 - Both Sex and Needle
S1 - Symptomatic
S2 - Named partner of infected
S3 - Anyone
A1 - Symptomatic
A2 - Named partner of infected
A3 - Anyone
C1 – Unnamed person from a venue screening

Type of Interview (29)
O – Original Interview (OI)
R – Reinterview Interview (RI)
C – Cluster Interview
P – Post-Test Counseling
U – Unable to Interview but Partners, Social Contacts, and/or Associates were initiated

Type Referral (30)
1 – Patient (Client)
2 - Provider
3 - Dual
4 - Contract
5 - Third Party

STD Dispositions (31)
A - Preventative Treatment
B - Refused Preventative Treatment
C - Infected, Brought to Treatment
D - Infected, Not Treated
E - Previously Treated for This Infection
F - Not Infected
G - Insufficient Information to Begin Investigation
H - Unable to Locate
I - Successful Interview/Recounsel
J - Located, Not Examined, Treated, and/or Interview
K - Sent Out Of Jurisdiction
L - Other
Q - Administrative Closure
V - Domestic Violence Risk
X - Patient Deceased
Z - Previous Preventative Treatment

HIV Dispositions STD Dispos G – X are applicable (31)
1 - Previous Positive
2 - Previous Negative, New Positive
3 - Previous Negative, Still Negative
4 - Previous Negative, Not Re-tested
5 - Not Previously Tested, New Positive
6 - Not previously Tested, New Positive
7 - Not Previously Tested, Not Tested Now

900 Case Status (19)
01 - HIV Negative result - The patient has tested HIV negative.

02 - New HIV Case requiring partner services The patient is newly diagnosed HIV positive.

03 - Prior-positive HIV case; New Partner services - The patient is a previously known HIV positive case requiring partner services due to being not previously known to health department as a named case.

04 - Prior-positive HIV case; New Partner Services - The patient is a previously reported HIV positive case requiring partner services due to other new STD infection or pregnancy.

05 - Prior-positive HIV case; New Partner Services The patient is a previously known or reported HIV positive case requiring partner services due to being identified as a sexual or social contact to an STD or HIV case.

06 - Other - None of the above 900 status apply to the patient but the status is known. Specify details within notes.

09 - Unknown - The patient HIV status is unknown.

Standard Documentation Abbreviations (59)
Bic - Bicillin
C/B - Call back/Called back
CLIX - Cluster Interview
CX - Contact
CL - Cluster
CSW - Commercial Sex Worker
FB - Field Blood
FR - Field Record
FV - Field Visit
HX - History
IM - Intramuscular
IP - Index Patient
IX - Interview
LX – Lesion
MSM - Men who have Sex with Men
FR - Field Record
OI - Original Interview
OP - Original Patient
P/C - Phone Call
Pt - Patient
RI - Reinterview
RS - Record Search
SX - Symptoms
TX - Treatment
PTC - Post-test counsel
W/ - With
WBI - Will be in
W/O - Without

Disposition Date (32)
Newly Examined and Treated - Use the date of treatment.
Newly Examined, not Treated - Use the date of examination.
Previously Examined and/or Treated - Use the date the partner/cluster investigation is closed.
Not Examined - Use the date the investigation is closed.

Internet Outcome (36)
I1 – Informed-Urgent Matter
I2 – Informed-General Exposure
I3 – Informed-Disease Specific
I4 – Demographics Found-routine Follow-up
I5 – Unknown Outcome
I6 – Not enough Info to Begin Investigation

Interviewed? (42)
01 Accepted
02 Refused

Notifiability (46)
01 No - Partner is deceased
02 No - Partner is out of jurisdiction
03 No - Partner has a risk of domestic violence
05 No - Partner is known to be previously positive
06 Yes - Partner is notifiable
88 Other

Notification Plan (47)
01 Client notification
02 Provider notification
03 Dual notification
04 Contract
05 Third-party notification

Notification Method (48)
01 Client notification
02 Provider notification
03 Dual notification
05 Third-party notification
06 Refused Notification

Self-reported HIV Results (49)
01 Positive
02 Negative
03 Preliminary positive
04 Indeterminate

Testing Confirmed (50)
01 Positive/Reactive
02 NAAT-positive
03 Negative

Refered to HIV Testing (51)
0 No
1 Yes

HIV Testing Performed (53)
0 No
1 Yes

Referral Test Result (54)
01 Positive/Reactive
03 Negative
04 Indeterminate
05 Invalid
06 No result

Results Provided (55)
0 No
1 Yes

Refered to Medical Care (Referral 2) (56)
0 No, client was not referred to HIV medical care/ evaluation/treatment.

1 Yes, referred to HIV medical care/examination/ treatment.

If yes, did client attend first appointment (57)
02 Confirmed – Accessed service
03 Confirmed – Did not access service
99 Don't know

Comprehensive Field Record Instructions

The Comprehensive Field Record (CFR) is divided into five sections which group like pieces of information. This template is intended to be a one page documented with printing on both sides of the page. This document is also designed to fit into standard STD pouches. This can be accomplished by simply folding the template in half.

Section 1, Page 1 top, left side of the document, contains patient demographic and locating information. Most of the information found in this section is the same as the previous version of the field record. The Race, Ethnicity (now labeled "Hispanic"), and Gender have been updated to include new options. New additions to the Field Record (FR) in this section include Internet Alias and Internet Site/System. Instructional Items 1 – 15, pages 2 - 3.

Section 2, Page 1 top, slightly off-centered, contains epidemiological and medical information. Most of the information found in this section is the same as the previous version of the field record. New additions to the FR in this section include Interview Only and 900 Case Status. Instructional Items 16 – 26, pages 3 - 5.

Section 3, Page 1 top, right side, contains field investigation outcomes. Most of the information found in this section is the same as the previous version of the field record. The only new addition to the FR in this section is Internet Outcome. Instructional Items 27 – 37, pages 5 - 9.

Not listed as a section and located at the bottom of page 1 is form and OOJ (Out of Jurisdiction) related information. These fields are the same as the previous version of the FR. Instructional Items 38 – 41, page 9.

Section 4, page 2, top, contains 900, HIV and AIDS, Partner/Social Contact Information. This section is totally new to the FR. Instructional Items 42 – 58, pages 9 - 14.

Section 5, bottom of pages 1 and 2, contains space for field documentation and Notes. The documentation section divided into two sections to be used as needed. Instructional Item 59, page 14.

The additional page of codes and abbreviations is intended to be used when the complete instructions are not available.

Section 1: Patient Demographic Information

1 **Name:** Document the last, first and any aliases of the interviewed person.

2 **Address/City/Telephone Number:** Document the address where the patient currently resides if known. Include apartment number, city, 2-letter abbreviation for the state, and the primary telephone number where the patient can be reached.

3 **Age:** Document the patient's age at the time of initial exam for the earliest condition reported on this interview record. Document '0' if age is less than one year or '99' if unknown.

Date of Birth: Document the patient's date of birth. Leave blank if unknown.

4 **Race:** Place an "X" in as many boxes as applicable. Base on the racial group(s) with which the *patient* self identifies.

AI/AN (American Indian or Alaska Native): A person having origins in any of the original peoples of North and South America (including Central America).
A (Asian): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
B (Black or African American): A person having origins in any of the black racial groups of Africa.
NH/PI (Native Hawaiian or Other Pacific Islander): A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
W (White): A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
U (Unknown): The patient could not answer this question for any reason.
R (Refused): The patient refused to answer this question.

5 **Hispanic:** Place an "X" in the appropriate box to identify the ethnic group with which the *patient* self identifies. Hispanic origin means a person of Spanish, Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Y - Yes, Hispanic/Latino
N - No, not Hispanic/Latino
U - Unknown
R - Refused to answer

6 **Current Gender:** Place an "X" in the appropriate box to indicate patient's self identified gender.

1 - **M** - Male
2 - **F** - Female
3 - MTF - Male to Female Transgender
4 - **FTM** - Female to Male Transgender
5 - **U** - Unknown
6 - R - Refused to Answer

7 **Marital Status:** Place an "X" in the appropriate box indicating marital status at the time of the interview or morbidity report.

S - Single, Never Married
M - Married
SEP - Separated
D - Divorced
W - Widowed
C - Cohabitation
U - Unknown
R - Refused to Answer

8 **Internet Alias/E-mail Address:** Document the patient's primary Internet alias or e-mail address used for receiving communications through the internet.

9 **Internet Site/System:** Document the website or internet system that corresponds to the Internet Alias or E-mail Address documented in item 8.

10 **Height:** Document the approximate or specific height of the patient.

11 **Size/Build:** Document the approximate or specific weight or body type of the patient.

12 **Hair:** Document the description of the patients hair, including color, length, and/or style as needed.

13 **Complexion:** Document the approximate or specific skin tone/hue of the patient.

14 **Employment:** Document as specifically as possible the details of the patients current employment situation, including where, hours worked, location, etc.

15 **Other:** Document any additional demographic information.

Section 2: Epidemiological/Medical Information

16 **Interview Only FR:** Document whether, yes or no, an interview is the purpose of the field investigation.

17 **Referral Basis:** Document the reason (referral basis) why the patient is being followed-up in the field.

PARTNER - Persons having sexual activities (of any type) or sharing needles with the Index patient.
- **P1** - Sex Partner
- **P2** - Needle sharing Partner
- **P3** - Both Sex and Needle sharing Partner

SOCIAL CONTACT - Persons named by an infected person (e.g., the Index patient or an infected partner, social contact, or associate).
- **S1** - Person who has or had symptoms suggestive of the Condition(s) documented.
- **S2** - Person who is named as a sex partner of a known infected person.
- **S3** - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk).

ASSOCIATE - Persons named by an uninfected partner, social contact, or associate.
- **A1** - Person who has or had symptoms suggestive of the Condition(s) documented.
- **A2** -Person who is named as a sex partner of a known infected person.
- **A3** - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk).

COHORT - **C1** - A person identified through outreach screening efforts as a result of case investigation (i.e., common geographical area of residence or hangout). The person was **not individually named** by anyone interviewed during case investigation.

POSITIVE LAB TEST - This record is initiated for follow-up on a positive laboratory test result obtained through screening, private physicians, or other sources.
- **T1** - Positive Test Result

T2 - Case Report
T3 - Clinic Walk-In
T4 - Second Positive Test

OOJ/ICCR (Out of Jurisdiction/Interstate Communication Control Records) – This record is initiated due to information obtained from another jurisdiction.

1 - Partner
2 - Social Contact or Associate
3 - Positive Lab Test

The following Referral Basis categories are unique to STD*MIS 5.0 and above. It is up to the local jurisdiction whether these are to be used for other purposes.

F1 - Congenital Follow-Up
F2 - 900 Re-Counsel
F3 - Test of Cure
F4 - Treatment Restart
F5 - Treatment Only
F6 - Vaccination
M1 - Maternal Follow-up
M2 - Infant Follow-up

Document the condition being investigated in the columns titled Disease 1 and Disease 2 as warranted.

18

Pregnant: Place an "X" in the appropriate box to indicate the patient's current pregnancy status. If the patient is currently pregnant, document the duration of the pregnancy in weeks. If the duration of the pregnancy is not known, document the patient's best estimate. Y - Yes, N - No, U - Unknown.

19

900 Case Status: Document the patient's HIV status.

01 - HIV Negative result - The patient has tested HIV negative.
02 - New HIV Case requiring partner services The patient is newly diagnosed HIV positive.
03 - Prior-positive HIV case; New Partner services - The patient is a previously known HIV positive case requiring partner services due to being not previously known to health department as a named case.
04 - Prior-positive HIV case; New Partner Services - The patient is a previously reported HIV positive case requiring partner services due to other new STD infection or pregnancy.
05 - Prior-positive HIV case; New Partner Services The patient is a previously known or reported HIV positive case requiring partner services due to being identified as a sexual or social contact to an STD or HIV case.
06 - Other - None of the above 900 status apply to the index patient, partner, or social contact but the status is known. Specify details within notes.
09 - Unknown - The patient HIV status is unknown.

20

Original patient ID: Document the control number, medical record number, case number, or other locally assigned identifiers. If a computerized case management system is utilized it is essential that the related control number from the Interview Record of the original patient be recorded here.

21

Exposure to Original Patient: Document the Index Patient's contact with the partner.

First Exposure - Document the date of the first sexual/needle-sharing exposure to the Index patient.

Freq. (Frequency) - Document the frequency (number) of sexual/needle-sharing exposure(s) to the Index patient between the first and last (most recent) exposure(s). This should be described as specifically as possible: 1x = one time, 2x/wk = two times a week, etc. If the frequency is unknown, document "99".

Last Exposure - Document the date of the last (most recent) sexual/needle-sharing exposure.

NOTE: Exposure information should only be documented for partners of the Index patient; only what the Index patient claimed as exposure should be documented, NOT what the partners claimed as exposure.

22 **Examination:** Document the date, test result, and provider for each test performed on this partner/cluster/HIV-positive or STS - positive reactor.

23 **Treatment:** Document the date, drug, dosage, and provider for each medication for this partner/cluster/HIV - positive or STS - positive reactor.

24 **Initiating Agency:** Document the appropriate FIPS county code of the initiating agency.

25 **Invest. Agency (Investigating Agency):** If different from above, Document the name or code number of the health department or other agency actually conducting the investigation.

26 **Clinic Code:** If applicable, enter the specific clinic code identifying the initiating clinic.

Section 3: Investigation Outcomes

27 **Interviewer Number:** Enter the number of the DIS who initiated the Field Record for follow-up.

28 **Date Initiated:** Enter the date this individual is initiated for DIS follow-up.

29 **Type Interview:** Enter the code for the type of interview that provided sufficient information in order to initiate this Field Record. If this Field Record is not for a partner/cluster investigation, leave blank.

O -Original Interview (with the original patient)
R -Re-Interview (with the original patient)
C -Cluster Interview (original patient, partner, cluster)
P -Posttest Counseling Session (original patient)
U -Unable to Interview*

* Partners, social contacts, or associates were initiated although the original partner "as not interviewed" (includes those records initiated from a record search of previous cases).

30 **Type of Referral:** (For partner/clusters only) This describes how initiated contacts, social contacts, and associates are brought to examination, brought to treatment, and/or notified of exposure. This documentation will take place at the time of the disposition (closure) of the field record. Document the type of referral for each condition.

1 - Patient (Client): No health department involvement in the referral of this partner, social contact, or associate.

2 - Provider: DIS or other health department staff were involved in the referral of this partner, social contact, or associate.

3 - Dual: The HIV-infected patient informs the partner of his/her serostatus in the presence of the PS provider.

4 - Contract: The PS provider and HIV-infected patient negotiate a time frame for the patient to inform his or her partners of their possible exposure to HIV. If the patient is unable to inform a partner within an agreed-upon time, the provider has the permission to notify and refer partners

to HIV counseling, testing, and other support services.

5 - Third Party: Notification of patient conducted by non-health department provider.

31

Dispo (Disposition): Document the STD or HIV disposition code from the field record for each Condition(s):

STD Dispositions

A - Preventative Treatment - The partner/cluster was examined and preventatively treated but the infection was not found by lab tests/clinical evidence.

B - Refused Preventative Treatment - The partner/cluster was examined and infection was not found; however, the partner/cluster refused preventive therapy.

C - Infected, Brought to Treatment - The patient was examined or treated (for the suspected infection) as, direct result of this field investigation. If the individual was treated prior to the initiation of this Field Record, the dispositions will be "E."

D - Infected, Not Treated - Information from a health care provider indicates the presence of an STD infection but adequate treatment was not administered.

E - Previously Treated for This Infection - The patient was adequately treated for the disease since the last exposure but prior to the initiation of a Field Record.

F - Not Infected - The tests/exam for the suspected disease is negative and preventive therapy was not required for this individual.

G - Insufficient Information to Begin Investigation - There is not sufficient information to begin an investigation. This disposition should always be discussed with a supervisor. This is an administrative disposition and should not be used if any investigative effort is expended. In such instances a disposition "H -Unable to Locate" is the correct one. When this disposition is used on a Field Record that was received from an out-of-jurisdiction location, it should also be transmitted to the initiating jurisdiction.

H - Unable to Locate - The patient was not found after a thorough DIS investigation. This disposition should always be reviewed with a supervisor. To ensure quality control, it is recommended that the following resources be exhausted before this disposition is used: Department of Motor Vehicles, detention centers, major hospital, probation authorities, major community health centers, community-based organizations, etc. If the infection status of the patient is known, use disposition "D".

I - Successful Interview/Recounsel – This disposition should be used in the situation where the only field activity required on a patient is to conduct an interview and the interview was conducted on the patient. If the interview was not conducted use another disposition, such as H - Unable to Locate or J – Located, Not Examined and/or Interviewed, to indicate why the interview was not conducted.

J - Located, Not Examined and/or Interviewed - The patient was found but refused examination and/or an Interview. This disposition should always be reviewed and initialed by a supervisor before being given as final.

K - Sent Out Of Jurisdiction - The patient resides or has moved outside of the local jurisdiction and locating information is available to forward it for continued investigation.

Note: Appropriate action should be taken to forward all necessary information to the new jurisdiction.

L - Other - is disposition is to be used when none of the other dispositions apply. Document the reason why this disposition was selected and discuss with a supervisor prior to using this disposition.

Note: patients that are deceased should receive a disposition of X – Patient Deceased.

Q - Administrative Closure -Though a field record was initiated through the course of the investigation it was determined that the field record should be closed administratively. This disposition should be discussed with the supervisor prior to use.

V – Domestic Violence Risk – No follow-up completed due to provider (private or public) assessed that contacting the partner or cluster could pose the risk of domestic violence to the index patient, partner, or cluster.

X - Patient Deceased - through the course of the investigation the patient was determined to be deceased.

Z - Previous Preventative Treatment – The patient has received prophylactic treatment relevant to the current investigation prior to the involvement of the DIS who is working the current field record. A patient can only receive preventative treatment once per incidence unless the patient is re-exposed to a condition.

HIV Dispositions
1 - Previous Positive -The patient had a previous positive HIV test.

2 - Previous Negative, New Positive -The patient has seroconverted.

3 - Previous Negative, Still Negative -The patient still has a negative test result.

4 - Previous Negative, Not Re- Tested -The patient has a negative result, but is not retested at this time due to a recent test or other circumstances.

5 - Not Previously Tested, New Positive -The patient has no documented previous test and is a new HIV - positive.

6 - Not Previously Tested, New Negative -The patient has not been previously tested (or is unable to document previous test) and has tested negative for this investigation.

7 - Not Previously Tested, Not Tested Now -The patient has not been previously tested and is still not tested after investigation.

G - Insufficient Information to Begin Investigation - There is not sufficient information to begin an investigation. This disposition should always be discussed with a supervisor. This is an administrative disposition and should not be used if any investigative effort is expended. In such instances a disposition "H -Unable to Locate" is the correct one. When this disposition is used on a Field Record that was received from an out-of-jurisdiction location, it should also be transmitted to the initiating jurisdiction.

H - Unable to Locate - The patient was not found after a thorough DIS investigation. This disposition should always be reviewed with a supervisor. To ensure quality control, it is recommended that the following resources be exhausted before this disposition is used: Department of Motor Vehicles, detention centers, major hospital, probation authorities, major community health centers, community-based organizations, etc. If the infection status of the patient is known, use disposition "D".

I - Successful Interview/Recounsel – This disposition should be used in the situation where the only field activity required on a patient is to conduct an interview and the interview was conducted on the patient. If the interview was not conducted use another disposition, such as H - Unable to Locate or J – Located, Not Examined and/or Interviewed, to indicate why the interview was not conducted.

J - Located, Not Examined and/or Interviewed - The patient was found but refused examination and/or an Interview. This disposition should always be reviewed and initialed by a supervisor before being given as final.

K - Sent Out Of Jurisdiction - The patient resides or has moved outside of the local jurisdiction and locating information is available to forward it for continued investigation.

Note: Appropriate action should be taken to forward all necessary information to the new jurisdiction.

L - Other - is disposition is to be used when none of the other dispositions apply. Document the reason why this disposition was selected and discuss with a supervisor prior to using this disposition.

Note: patients that are deceased should receive a disposition of X – Patient Deceased.

Q - Administrative Closure -Though a field record was initiated through the course of the investigation it was determined that the field record should be closed administratively. This disposition should be discussed with the supervisor prior to use.

V – Domestic Violence Risk – No follow-up completed due to provider (private or public) assessed that contacting the partner or cluster could pose the risk of domestic violence to the index patient, partner, or cluster.

X - Patient Deceased - through the course of the investigation the patient was determined to be deceased.

Note: If HIV testing was conducted, the assumption for the disposition rationale is that pre-test counseling was conducted. Only in disposition "J" can "refusal of pre-test counseling" be documented. For the two dispositions where persons are "not re-tested" and "not tested now", that may be due to recent testing, acceptance of counseling, but refusal of testing, etc.

32

Dispo Date: Use the appropriate date as it relates to the following examination or treatment situation:
1. Examined and treated - Use the date of treatment.
2. Examined not treated - Use the date examined (tested). Document the HIV disposition date this way.
3. Not examined - Use the date the investigation is closed.
4. Previously Examined and/or Treated - Used the date the investigation is closed

33

New Case Number: If applicable, enter the new case number for the patient. The case numbering system is a local area issue.

34

Diagnosis: If partner/cluster is dispositioned as infected, whether previously or currently, document the diagnosis.

35

Worker #: Enter the number of the worker who performed this investigation (brought field record to final disposition).

36

Internet Outcome: Document the outcome of internet based activities.
The I1, I2, and I3 Internet Outcomes can be used in two different fashions depending on programmatic policies as well as applicable laws, regulations and statutes of a given project area. These are considered to be positive outcomes in that contact was made with a client via the internet. However they can be used either as stand-alone outcomes, that is only one is used regardless of the situation, or they can be used in hierarchical formation, with I1 being the first attempt made, I2 the second attempt, and so forth.

Note: The first character is an uppercase "i."

I1 - Informed patient of urgent health matter
The client was sent an internet communication concerning a non-specific health matter with direction to

contact the IPS worker for additional details *and* the client responded, whether positively or negatively, to the internet referral. This outcome is not dependent upon whether the examination was completed or not. The disposition code on the field record will summarize the client's final outcome. I1 may be used in situations where programmatic policies, local laws, regulations, and/or statutes limit the type of internet messaging that can be used.

I2 - **Informed patient of general disease exposure**
The client was sent an internet communication concerning a non-specific health matter with direction to contact the IPS worker for additional details and the client responded, whether positively or negatively, to the internet referral. This outcome is not dependent upon whether the examination was completed or not. The disposition code on the field record will summarize the client's final outcome. I2 may be used in situations where programmatic policies, local laws, regulations, and/or statutes limit the type of internet messaging that can be used.

I3 - **Informed patient of disease-specific exposure**
The client was sent an internet communication concerning a non-specific health matter with direction to contact the IPS worker for additional details and the client responded, whether positively or negatively, to the internet referral. This outcome is not dependent upon whether the examination was completed or not. The disposition code on the field record will summarize the client's final outcome. I3 may be used in situations where programmatic policies, local laws, regulations, and/or statutes limit the type of internet messaging that can be used. In some jurisdictions clients will need to agree to receive disease specific information before the information can be sent by the IPS worker.

I4 - **Demographics known, traditional Follow-Up**
The client was contacted via the internet and provided locating information, such as a home address or telephone number, so that the worker can provide traditional field follow-up. Locating information may also be found through other electronic means though the investigation began as an internet investigation.

I5 - **Unknown outcome**
The IPS worker attempted to contact the client via the internet but there was no response from the client. It may not be known if the electronic contact information is valid and there may be no means to confirm if an account is active. All other known investigative avenue to pursue the client have been utilized including re-interviewing the index patient for additional information.

I6 – **Unsuccessful/negative outcome**
The IPS worker contacted the client via the internet however the client has not responded in a positive manner. Repeated attempts may have been tried and all other known investigative avenues to pursue the client have been used including re-interviewing the index patient for additional information.

I7 – **Insufficient Information**
The IPS worker attempted to contact the client via the internet but the client's account is no longer valid or the website given is no longer functional. The IPS worker may only have partial electronic contact information and hence cannot begin an investigation.

37 **Post-test Counseled:** If the disease investigated is HIV, determine whether or not partner or cluster was counseled (yes/no).

38 **FR Number (Field Record Number):** This is a pre-printed or system-generated number which may be entered on the Interview Record in the FR Num. section (Item 65 on Interview record**.**

39 **OOJ (Out of Jurisdiction) No.:** Enter the new Field Record Number that will be used in the receiving area if this is sent to another jurisdiction for completion.

OOJ Area (Out -of- Jurisdiction): Enter the name of the area where the out-of jurisdiction Field Record is

40 sent.

41 **Due Date:** Enter the expected date for the completion of the investigation by the receiving area (generally two weeks).

Note: 900 PS Information is replicated on the Field Record and Cluster Interview Templates but should only be completed once on either template per partner and not on both. It is left to the local program area to determine which data collection instrument, if any, is to be used to collect this information.

Section 4: 900 Partner Services – Partner Information

42 **Interviewed:** Document whether the index patient or the index patient's partner accepted or declined enrollment into Partner Services (i.e., did they accept the interview).

01	Accepted	The index patient or partner enrolled in PS.
02	Refused	The index patient or partner chose not to enroll in PS.

43 **Interview Date:** Document the date that the interview or prevention counseling session was conducted.

44 **Sex at Birth:** Place an "X" in the appropriate box to indicate patient's gender at birth.
M - Male
F - Female

45 **If <u>additional</u> Gender, <u>Specify</u>:** Document the specific gender information of the patient if other selections do not apply (i.e. intersex, two-spirited, etc.).

46 **Notifiability:** Using the codes below, document whether or not a named partner is determined to be eligible for notification of exposure. Partners that are found to be previously positive, deceased, or for which there is a risk of domestic violence are not considered to be notifiable.

01	No - Partner is deceased	The partner is no longer alive.
02	No - Partner is out of jurisdiction	The partner resides out of the jurisdiction in which the provider is authorized to provide services
03	No - Partner has a risk of domestic violence	The provider has assessed that contacting the partner could pose a risk of domestic violence to the index patient or partner.
05	No – Partner is known to be previously positive	The partner has a documented history of testing/diagnosed HIV positive.
06	Yes - Partner is notifiable	The partner is able to be notified of his/her exposure to HIV.
88	Other	

47 **Notification <u>Plan</u>:** Using the values below, document the method agreed upon by IP and DIS for notifying the partner(s) and clusters of potential HIV exposure.

01	Client Notification	The HIV-infected patient informs his or her partners of their possible exposure to HIV and refers them to counseling, testing, and other support services after receiving guidance from the PS provided

02	Provider notification	The PS provider, with the consent of the HIV-infected patient, takes the responsibility for informing the partner of his/her possible exposure to HIV and referring them to counseling, testing, and other support services.
03	Dual notification	The HIV-infected patient informs the partner of his/her serostatus in the presence of the PS provider.
04	Contract	The PS provider and HIV-infected patient negotiate a time frame for the patient to inform his or her partners of their possible exposure to HIV. If the patient is unable to inform a partner within an agreed-upon time, the provider has the permission to notify and refer partners to HIV counseling, testing, and other support services.
05	Third-party notification	A notification strategy whereby the partner was notified by a professional other than the health department provider (e.g., a private physician) of his or her possible exposure to HIV.

48 **Actual Notification Method Used:** Document the method used to notify each notifiable partner that they have been exposed to HIV.

01	Client notification	The HIV-infected patient informs his or her partners of their possible exposure to HIV and refers them to counseling, testing, and other support services after receiving guidance from the PS provided.
02	Provider notification	The PS provider, with the consent of the HIV-infected patient, takes the responsibility for informing the partner of his/her possible exposure to HIV and referring them to counseling, testing, and other support services.
03	Dual notification	The HIV-infected patient informs the partner of his/her serostatus in the presence of the PS provider.
05	Third-party notification	A notification strategy whereby the partner was notified by a professional other than the health department provider (e.g., a private physician) of his or her possible exposure to HIV.
06	Refused notification	The index client's partner refused to be informed of his or her possible exposure to HIV.

Self Reported HIV Test Result: Document the partner's self-reported HIV test result at the time of notification. When asking about the "Self-Reported Test Result" it is very important that the provider ask about the test result from the most recent HIV test. Ensure that the partner understands that he/she is being asked to report his/her test results and not what he/she believes their status is.

49

01	Positive	The patient reports that his/her HIV serostatus is positive based on a confirmatory test result.
02	Negative	The patient reports that his/her HIV serostatus is negative.
03	Preliminary positive	The patient reports that he/she received a "Preliminary positive" test result (i.e., the patient had a reactive HIV rapid test but did not receive the results of the associated conventional confirmatory test).

04	Indeterminate	The patient reports that he/she received an "Indeterminate" test result (i.e., the patient received results but those results did not conclusively indicate whether he/she is HIV-positive or HIV-negative).
66	Not asked	The provider did not ask the patient about his/her HIV serostatus.
77	Declined	The patient declines or is unwilling to report his/her HIV serostatus.
99	Don't know	The patient reports that he/she is unaware of his/her HIV serostatus.

50 **Date of Last (900) HIV Test:** Document the date of the patient's last HIV test.

51 **Referred to Testing (Referral 1):** Document whether the partner was referred to HIV testing.

0	No, the patient was not referred to HIV testing
1	Yes, the patient is referred to HIV testing.

52 **Referral Date:** Document the date on which the partner was referred to HIV testing.

53 **Testing Performed:** If the partner was referred to HIV testing, indicate whether or not the partner was tested for HIV.

0	No	The patient did not receive an HIV test as a result of a referral to this agency/site for CTR.
1	Yes	The patient received an HIV test as a result of a referral to this agency/site for CTR.

54 **Referral Test Result:** If the partner was referred to testing and tested, document the result of the referred test.

01	Positive/Reactive	A test result that is reactive on an initial ELISA test, repeatedly reactive on a second ELISA run on the same specimen, and confirmed positive on a Western blot or other supplemental test indicating that the patient is infected with HIV.
03	Negative	A test result that is non-reactive on an initial ELISA test indicating the absence of HIV infection or ELISA was repeatedly reactive and a confirmatory test (Western Blot or IFA) was negative.
04	Indeterminate	A test result that has not been precisely determined. A possible result of a Western-blot, which might represent a recent HIV infection or a false positive.
05	Invalid	The test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport.
06	No result	No result was obtained even though the specimen was drawn (e.g., blood sample hemolyzed, blood tube broke, blood tube lost in transit, unable to draw blood from veins).

55 **Result Provided (Post):** Document whether the partner was informed of their HIV test result.

0	No	The result of this HIV test was not provided to the partner.
1	Yes	The result of this HIV test was provided to the partner.

56

Referred To Medical Testing (Referral 2): For 900 positive contacts, document whether the partner was referred to HIV medical care/evaluation/treatment.

0	No, patient was not referred to HIV medical care/ evaluation/treatment	No referral was made to medical care.
1	Yes, referred to HIV medical care/evaluation/ treatment	A referral was made to medical care.

57

If Yes, did Patient Attend First Appt.: For 900 positive contacts, document whether the patient attended the first appointment of the medical referral.

01	Pending	The referring agency has not yet confirmed whether the patient accessed the service to which he or she was referred.
02	Confirmed- Accessed service	The referring agency has confirmed that the patient accessed the service to which they were referred.
03	Confirmed- Did not access service	The referring agency has confirmed that the patient had not accessed the service to which they were referred.
04	Lost to follow-up	Within 60 days of the referral date (X702: Referral Date <60 days), access of the service to which the patient was referred can't be confirmed or denied.
05	No follow-up	The referral was not tracked to confirm whether the patient accessed the referred service.
99	Don't know	The referring agency doesn't know if the patient accessed the service to which they were referred.

Risk Factors

58

NOTE: Each risk factor should be addressed for last 12 months prior to the date of the interview.

NOTE: For each risk 1 – 4, the patient should be asked what type of sexual exposure occurred. Document the appropriate response, one response per risk factor.
Y – Yes, Anal or Vaginal Intercourse (with or without Oral Sex)
O – Yes, Oral Sex Only
U – Unspecified Type of Intercourse
N – No Sexual Exposure
R – Refused to Answer
D – Did Not Ask

NOTE: For each risk 5 – 8, document the appropriate response, one response per risk factor.
Y - Yes
N - No
R - Refused to Answer
D – Did not ask

1. Male - Sex with male?
2. Female - Sex with female?
3. Transgender - Sex with transgender?
4. Condom - Sex without using a condom?
5. IDU - Injection Drug Use?

6. Share Equipment - Shared injection drug equipment?
7. NIR - No risk identified.
8. Other

Section 5: Documentation and Field Notes

59 **Notes:** Document field activities using standardize abbreviations as well as any additional relevant information pertaining to the field investigation.