Thunder Bay District Health Unit

Fax

MAIN OFFICE
999 Balmoral Street
Thunder Bay, Ontario
P7B 6E7

Phone
(807) 625-5900

Toll free
in 807 area code
1-888-294-6630

Fax
(807) 623-2369

www.tbdhu.com

Date:

Dear

We have received a laboratory report of a case of **HIV** in a client under your care. It is our responsibility to report all such cases confidentially to the Ministry of Health and Long Term Care, however, we do not have all of the necessary information required to complete this reporting. Please complete **ALL** information as indicated below **in accordance with the Health Protection and Promotion Act, Section 25 and 26**. Please fax this completed form to (807) 625-4866 **within 5 business days regardless of whether or not client follow up has been completed.**

Please advise your patient that the Thunder Bay District Health Unit will be contacting them.

Your cooperation in this matter is appreciated.

Sincerely,

Sexual Health Program
(807) 625-5976

RE:

Address: _____
Phone # _____ Date of Birth: _____
Address: _____
Primary care provider: _____
Alias:_____ Ethnicity: _____

Reason for Testing:

☐ Routine Screening ☐ Contact Tracing ☐ Immigration screening
☐ Insurance ☐ Post-mortem ☐ Blood/organ donation
☐ Symptoms ☐ Pre-natal (EDC: _____)
☐ Other: _____

Has the client tested positive in the past for HIV?

Yes ☐ Where? _____ When?_____
No ☐

Disease diagnosed: ☐ HIV ☐ AIDS
Is the patient deceased? ☐Yes, date of death: _____☐ Cause: _____
☐ No

Symptoms (check all that apply):

✓	**Symptom**	**Start Date:**	**End Date:**
	Asymptomatic	----------	----------
	Fever		
	Rash		
	Lymphadenopathy		
	Fatigue/Lethargy		
	Sore throat		
	Arthralgia/myalgia		
	Unexplained weight loss		
	Oral hairy leukoplakia		
	Other, please specify:		

Exposure setting (check all that apply):

✓	Setting	✓	Setting
	Bath house		Other personal services (specify)
	Blood exposure through shared accident		Other social venue (specify):
	Correctional facility		Tattoo and piercing
	Encounter following a major event:		Travel outside province/country (specify):
	Occupational exposure to potentially contaminated body fluids		Travelled to or lived in country where HIV is endemic (specify):
	Under-housed/homeless		Unknown
	Electrolysis and acupuncture		Other:

Medical risk factors (check all that apply):

✓		✓	
	Received blood or blood products (specify when and where):		Received organ/tissue transplant or donor insemination (specify when and where):
	Co-diagnosis /co-infection with existing STI (specify):		Repeat STI
	Correctional facility		Pregnant
	Client was born to an HIV positive parent		Unknown
	Invasive surgical/dental/ocular procedure (specify where and when):		Other:

Behavioural Risk Factors (check all that apply):

✓		✓		✓	
	Anonymous sex		>1 sex contact in the last 6 months (#___)		Shared other drug equipment
	Condom breakage		No condom used		Shared sex toys
	Consumed breastmilk		New contact in past 2 months		Strategic positioning
	Contact lived in or visited country where HIV is endemic (specify)		Contact visiting from outside province or country (specify)		Sex trade worker
	Fighting/biting/torture/blood brother		Contact is HIV positive		Sex with opposite sex
	Inhalation drug use		Serosorting		Sex with same sex
	Injection drug use		Sex for drugs/food/shelter/survival		Sex with sex trade worker
	Judgement impaired by alcohol/drugs (specify)		Sex with transgender person		Unknown
	Met contact through internet		Shared needles		Other:

To protect the health of the public we will contact the Canadian Blood Service about the donation or receipt of blood and will inform the client about this disclosure.

Blood Donation? ☐ No ☐ Yes
Date _____ City _____

Blood Transfusion ☐ No ☐ Yes
Hospital: _____ Date _____ City _____

Tuberculin Skin Test (recommended for all clients diagnosed with HIV)
Has client had TB skin test? ☐ Yes, date: _____ ☐ No ☐ Client refused
*Memo re: reporting active TB diagnosis to TBDHU
Note: A false negative tuberculin skin test (TST) can be caused in patients who have HIV infection and a low CD4 lymphocyte count, malnutrition, major viral illness, recent immunization (MMR< Varicella), and young age (<6 months).

Other sexually transmitted infection screening
What other STI tests have been done? ☐ Chlamydia ☐ Gonorrhea ☐ Hep B ☐ Hep C ☐ Syphilis ☐ Other:
Please indicate results: _____ _____ _____ _____ _____

Last confirmed HIV negative test date: _____

Has client ever been tested out of province or in another country?
☐ No ☐ Yes Please specify: _____

HIV Education
Received pre-test counselling? ☐ No ☐ Yes ☐ Unknown
Case informed of test results? ☐ No ☐ Yes ☐ Unknown

Post-test counselling (please check what sections have been completed):

☐ No ☐ Yes Ensure that your patient understands the test results, natural progression of HIV infection and the difference between HIV and AIDS
☐ No ☐ Yes Counselled on modes of transmission of HIV (blood, pre-ejaculate/semen, anal/vaginal secretions, breastmilk) and window period for transmission
☐ No ☐ Yes Counselling completed for safer sex and drug-use practices
☐ No ☐ Yes Discuss notification of sexual and drug-sharing partners
Contacts are defined as those who have had intimate sexual contact, shared drug equipment or other risk activity with client from outer limit of time frame. Time frame is 14 weeks prior to lab slip documentation of a negative HIV result or if no prior HIV testing, it includes all contacts since 1978
☐ No ☐ Yes Future partner notification of HIV status prior to risk activity and reinforce measures for protection
☐ No ☐ Yes Instruct your patient never to donate blood, semen, breastmilk or body organs;
☐ No ☐ Yes Assess client's support system and provide with appropriate referrals;
☐ No ☐ Yes Discuss the recommendation to inform other health care attendants, dentists, etc.
☐ No ☐ Yes Provide information for the HIV/AIDS Legal Clinic of Ontario (HALCO) regarding legal information related to HIV

Contact Notification:
Who will notify partner(s)?: Number of contacts: _____
☐ Client will notify their contacts
☐ Health care provider to provide contact notification
☐ Unfollowable – Client does not have sufficient information to contact partner(s)
☐ Public Health – Client has requested anonymous notification of partner(s). Please provide any known, identifying information about each partner including name, gender, address, telephone number, age/date of birth

Contact Name	Sex	DOB/Age	Address	Telephone

- Please write out any additional info on separate sheet of paper and attach to this letter

Comments: _____

_____

_____

_____

Please fill out this section if your client has a diagnosis of AIDS

Date of diagnosis (Y/M/D) _____

Is the patient deceased? Yes, date of death: _____ Cause: _____ ☐ No

Address at time of first AIDS defining illness _____

DISEASES INDICATIVE OF AIDS (for AIDS cases only, check all that apply)

Diseases (Check all that apply	Date of Diagnosis _____ Y/M/D	Method of Diagnosis		**Diseases** (Check all that apply)	Date of Diagnosis _____ Y/M/D	Method of Diagnosis	
		Definitive	Presumptive			Definitive	Presumptive
Bacterial Pneumonia, recurrent				Lymphoma, Burkitt's (or equivalent term)			N/A
Candidiasis - bronchi, trachea or lung			N/A	Lymphoma, immunoblastic (or equivalent term)			N/A
Candidiasis, esophageal				Lymphoma (primary in brain)			N/A
Cervical cancer - invasive			N/A	Mycobacterium avium complex or M. Kansaii disseminated or extra pulmonary			
Coccidioidomycosis, disseminated or extrapulmonary			N/A	M. Tuberculosis, disseminated or extra pulmonary			
Cryptosporidiosis, chronic intestinal			N/A	M. Tuberculosis pulmonary			
Cryptococcosis extrapulmonary			N/A	Mycobacterium, of other species of unidentified species, disseminated or extra pulmonary			
Cytomegalovirus disease (other than liver, spleen or nodes)			N/A	Pneumocystis carinii pneumonia (PCP)			
Cytomegalovirus retinitis (with loss of vision)				Progressive multifocal leukoencephalopathy			N/A
HIV Encephalopathy			N/A	Salmonella septicemia, recurrent			N/A
Herpes simplex: chronic ulcer(s) (≥ 1 mo. duration) or bronchitis, pneumotis or esophagitis			N/A	Toxoplasmosis of brain			
Histoplasmosis, disseminated or extrapulmonary			N/A	**Wasting syndrome due to HIV**			**N/A**
Isosporiasis, chronic (intestinal >1 mo. duration)			N/A	**Disease affecting pediatric cases only (< 15 years old)**			
Kaposi's sarcoma				Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia			
				Bacterial infections, multiple or recurrent (excl. recurrent bacterial pneumonias)			N/A

Signature of Health Care Provider: _____ Date: _____