Thunder Bay District
Health Unit

**MAIN OFFICE**
999 Balmoral Street
Thunder Bay, ON
P7B 6E7

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

**FAX**
Sexual Health/
Street Outreach
**(807) 625-4866**



**www.tbdhu.com**

# Fax

## Sexual Health/Street Outreach

To

Company

Fax

From

Phone

Fax (807) 625-4866

Date

Pages

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We have received a positive HIV laboratory result for a client in your care. Please see the attached reporting form, and complete in accordance with the **Health Protection and Promotion Act, Section 25 and 26**. Please complete ALL information as indicated below and fax to 807-625-4866 within **5 business days regardless of whether client follow up has been completed**.

Please advise your patient that the Thunder Bay District Health Unit may contact them. Your cooperation in this matter is appreciated.

Thank you.

# HIV Follow-up Form

Please fax back to: 807-625-4866

Thunder Bay District Health Unit

Date: _____

To: _____

| | |
|---|---|
| **RE:** | |
| **Address** | |
| **Telephone #:** | **DOB** (yyyy/mm/dd): |
| **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?**<br>Where: | ☐ **No**<br>When: | ☐ **Yes** |
| **Disease diagnosed:** | ☐ **HIV** | ☐ **AIDS** |
| **Is the patient deceased?**<br>**Cause of death:** | ☐ **No** | ☐ **Yes, date of death:** |

| **Symptoms (check all that apply)** | **Start Date** | **End Date** |
|---|---|---|
| ☐ **Routine Screening** | | |
| ☐ **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) | |
|---|---|
| ☐ Bath house | ☐ Other personal services (specify) |
| ☐ Blood exposure through shared accident | |
| ☐ Correctional facility | ☐ Other social venue (specify) |
| ☐ Encounter following a major event | |
| ☐ Occupational exposure to potentially contaminated body fluids | ☐ Travel outside province/country (specify) |
| ☐ Under-housed/homeless | ☐ Traveled to or lived in country where HIV is endemic (specify) |
| ☐ Electrolysis and acupuncture | |
| ☐ Tattoo and piercing | ☐ Other: |
| ☐ Unknown | |

| 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) | ☐ Invasive surgical/dental/ocular procedure (specify where and when) |
| ☐ Correctional facility | ☐ Pregnant |
| ☐ Client was born to an HIV positive parent | ☐ Unknown |
| ☐ Repeat STI | ☐ 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 | ☐ Strategic positioning |
| ☐ New contact in past 2 months | ☐ Sex trade worker |
| ☐ Contact visiting from outside province or country (specify) | ☐ Contact lived in or visited country where HIV is endemic (specify) |
| ☐ 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 | ☐ Sex with transgender person |
| ☐ Unknown | ☐ Met contact through internet |
| ☐ Shared needles | ☐ Other: |
| ☐ Judgement impaired by alcohol/drugs (specify) | |

**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.**

| **Has the client ever donated blood?** ☐ **No** ☐ **Yes** | |
|---|---|
| Date | City |
| | |
| **Has the client ever had a blood transfusion?** ☐ **No** ☐ **Yes** | |
| Date | City |
| Hospital | |

**Tuberculin Skin Test (recommended for all clients diagnosed with HIV)**

Has client had TB skin test? ☐ No ☐ Yes, date: ☐ 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 or 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):**

| | | |
|---|---|---|
| Ensure that your patient understands the test results, natural progression of HIV infection and the difference between HIV and AIDS. | ☐ No | ☐ Yes |
| Anti-retro viral therapy treatment initiated or referral made to other agency to initiate treatment | ☐ 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 (all partners will be confirmed by Public Health) 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 | ☐ No | ☐ Yes |

| Contact Information | |
|---|---|
| Who will notify partner(s)?: | Number of contacts |
| ☐ Client to provide contact notification | |
| ☐ Health care provider to provide contact | |
| ☐ Unfollowable – Client does not have sufficient information to contact partner(s) notification | |
| ☐ 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 birthcient information to contact partner(s)notification | |

| Contact Name | Sex | DOB/Age |
|---|---|---|
| Address | Telephone | |

| Contact Name | Sex | DOB/Age |
|---|---|---|
| Address | Telephone | |

| Contact Name | Sex | DOB/Age |
|---|---|---|
| Address | Telephone | |

| 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

| Disease diagnosis (yyyy/mm/dd) |
|---|
| Is the patient deceased? ☐ No ☐ Yes, date of death: |
| Cause of death: |
| 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) | Diagnosis Date (yyyy/mm/dd) | Method of Diagnosis | |
| | | Definitive | Presumptive |
| ☐ Bacterial Pneumonia, recurrent | | | |
| ☐ Candidiasis – bronchi, trachea or lung | | | |
| ☐ Candidiasis, esophageal | | | |
| ☐ Cervical cancer – invasive | | | |
| ☐ Coccidioidomycosis, disseminated or extrapulmonary | | | |
| ☐ Cryptosporidiosis, chronic intestinal | | | |
| ☐ Cryptococcosis extrapulmonary | | | |
| ☐ Cytomegalovirus disease (other than liver, spleen or nodes) | | | |
| ☐ Cytomegalovirus retinitis (with loss of vision) | | | |
| ☐ HIV Encephalopathy | | | |
| ☐ Herpes simplex: chronic ulcer(s) (≥ 1 mo. duration) or bronchitis, pneumotis or esophagitis | | | |
| ☐ Histoplasmosis, disseminated or extrapulmonary | | | |
| ☐ Isosporiasis, chronic (intestinal >1 mo. duration) | | | |
| ☐ Kaposi's sarcoma | | | |
| ☐ Lymphoma, Burkitt's (or equivalent term) | | | |
| ☐ Lymphoma, immunoblastic (or equivalent term) | | | |
| ☐ Lymphoma (primary in brain) | | | |
| ☐ Mycobacterium avium complex or M. Kansaii disseminated or extra pulmonary | | | |
| ☐ M. Tuberculosis, disseminated or extra pulmonary | | | |
| ☐ M. Tuberculosis pulmonary | | | |
| ☐ Mycobacterium, of other species of unidentified species, disseminated or extra pulmonary | | | |
| ☐ Pneumocystis carinii pneumonia (PCP) | | | |
| ☐ Progressive multifocal leukoencephalopathy | | | |
| ☐ Salmonella septicemia, recurrent | | | |
| ☐ Toxoplasmosis of brain | | | |
| ☐ Wasting syndrome due to HIV | | | |
| **Disease affecting pediatric cases only (< 15 years old)** | | | |
| ☐ Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia | | | |
| ☐ Bacterial infections, multiple or recurrent (excl. recurrent bacterial pneumonias) | | | |

**Signature of Health Care Provider:** **Date:**