

HIV CLASSIFICATIONS

Name (Last, First, Middle Initial)	Register No.	Date of Birth
Race: White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Nat. American <input type="checkbox"/>		
Country of birth	Facility and State	

Risk Factors: After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis, the patient had the following risk factors (respond to all categories) :

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|--|------------------------------|-----------------------------|----------------------------------|
| 1. Sex with male | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2. Sex with female | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 3. Injected nonprescription drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 4. Transfused clotting factor for bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 5. Heterosexual relations with any of the following: | | | |
| Injection drug user | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Bisexual male | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Person with hemophilia/coagulation disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Transfusion recipient with documented HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Transplant recipient with documented HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Person with HIV INFECTION or AIDS/unknown risk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 6. Transfused blood products (other than clotting factor) product _____ first _____ mo/yr last _____ mo/vr | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 7. Received organ/tissue transplant or artificial insemination | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 8. Health care worker or clinical laboratory worker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 9. Tattoo (while incarcerated) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

CDC HIV Classification (choose one)

- AL
 A2
 A3
 B1
 B2
 B3
 C1
 C2
 C3

Clinical conditions (Describe clinical status/conditions relevant to A, B, or C classification).

Evaluating clinician	Date
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