DH2293,
Revised January 2023

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BUSINESS REPLY SERVICE LICENCE NO. 7487
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Department of Health
Centre for Health Protection
Special Preventive Programme
(Attn:Consultant Physician)
2/F Wang Tau Hom Jockey Club Clinic
200 Junction Road East
Kowloon

九龍
聯合道東 200 號
橫頭磡賽馬會診所二字樓
特別預防計劃辦事處
顧問醫生

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DEPARTMENT OF HEALTH
HIV/AIDS Report Form

The HIV/AIDS voluntary reporting system has been in place since 1984. All doctors are encouraged to report patients with HIV/AIDS and to update status of the previously reported cases where appropriate. This is an anonymous and confidential system. Data collected is crucial for understanding the HIV epidemiology in Hong Kong and is used in global analysis only. Aggregate statistics are released quarterly and can be obtained at www.aids.gov.hk. For any query, please call 3143 7225 or email us at aids@dh.gov.hk. Completed form can be faxed to 2297 3239 or mailed to Special Preventive Programme, Centre for Health Protection, Department of Health.

Guidance notes for filling the form

Please complete ALL sections and '✓' in the appropriate box.

Section (A) – Report of HIV

[1] THIS is a ◯NEW report or ◯UPDATE of previous reported case

[2] Your reference code number[1]: _____

[3] Does the patient have a HK identity card? ◯Yes ◯No Document ID first 5 digits: _____

[4] Sex at birth[2] : ◯M ◯F (Please fill in box 1) ◯Others Gender identity[3]: ◯M ◯F ◯Non-binary

[5] Date of birth: / / (dd/mm/yyyy) or Age at last birthday:_____

[6] Ethnicity: ◯Chinese ◯Asian, specify: _____ ◯Caucasian ◯Black ◯Others: _____ ◯Unknown

[7] Suspected risk(s) for HIV infection[5]

a. **Suspected primary risk factor**

Please select...

b. Suspected secondary risk factor

Please select...

**If you selected:

(i)Occupational, please select: Health care worker: ◯Yes◯No

(ii)Organ transplant/transfusion of blood/blood products, please select(Haemophilia: ◯Yes ◯No)
Year of transplant/transfusion:_____

(iii)Perinatal, please write down mother's reference number:_____

(iv)Others, please specify:_____

Box 1

Pregnant[4]? ◯No ◯Yes

Gravida ____ Para ___ LMP _____ (dd/mm/yyyy)

Obstetric follow up clinic/ hospital: _____

Plan: ◯TOP ◯Continue pregnancy

Expected hospital/place of delivery: _____

[8] Suspected place of infection: ◯Hong Kong ◯Mainland China, specify: _____ ◯Others, specify: _____
◯Asked, but undetermined ◯Not asked

[9] Date of laboratory diagnosis in HK: _____ (dd/mm/yyyy)

[10] Confirmation test[6]: ◯Yes ◯No If Yes, by ◯Western Blot ◯Confirmatory Assay ◯PCR ◯others _____

[11] Name of Laboratory: _____ [12] Laboratory Number[7]: _____

[13] Previous HIV diagnosis outside HK: ◯No ◯Yes If yes, date: / / (dd/mm/yyyy) place: _____

[14] Any previous negative HIV test: ◯No ◯Yes If yes, date of last negative HIV test / / (dd/mm/yyyy)

[15] CD4 (cells/μl): _____ Date: _____ (dd/mm/yyyy)

Section (B) – Report of AIDS

[17] Has the patient developed AIDS[8]: ◯ Yes ◯ No (Go to Section C)

[18] If yes, the AIDS defining illness(es) is (are):

(i) Please select... Date of diagnosis: _____ (dd/mm/yyyy)

(ii) Please select... Date of diagnosis: _____ (dd/mm/yyyy)

(iii) Please select... Date of diagnosis: _____ (dd/mm/yyyy)

[19] CD4 (cells/μl) at AIDS: _____ Date: _____ (dd/mm/yyyy)

Section (C) – Report of Outcome

[20] Has the patient referred to/seen at public HIV clinic? ◯Yes ◯No If yes, referred on/seen at: _____ (dd/mm/yyyy)

[21] Has the patient defaulted follow up? ◯Yes ◯No If yes, last seen on: _____ (dd/mm/yyyy)

[22] Is the patient under private HIV medical care ◯Yes ◯No

[23] Has the patient left HK? ◯Yes ◯No If yes, last seen on: _____ (dd/mm/yyyy)

[24] Has the patient died? ◯ Yes ◯No If yes, date of death: _____ (dd/mm/yyyy) Cause: _____

Section (D) – Correspondence

Name of medical practitioner/NGO: _____ ◯in private practice ◯in public service

Correspondence Address: _____

Tel: _____ Fax: _____

Email: _____ Date: _____ (dd/mm/yyyy)

ALL INFORMATION WILL BE TREATED IN STRICTEST CONFIDENCE