

San Francisco Department of Public Health

HIV Health Services (HHS)

ARIES Registration Form

Level I – Data Requirements (Applicable to All Agencies)

Client Name: Last First Middle Name Mother's Maiden Name

- Current Gender: Male, Female, Transgender MTF, Transgender FTM, Other, Unknown, Client Refused to Report

Date of Birth: mm/dd/yy Agency Client ID: (agency use only) Agency Intake Date: mm/dd/yy

SHARE STATUS – Tab: Demographics – Agency Specifics

Share Status: O Share O Non-Share (Criteria met and documented in client chart)

ELIGIBILITY DOCUMENTATION - Tab: Eligibility – Eligibility Documents

Type: ARIES Consent Form

- Pending Obtained by this agency

Document Dated: \_\_\_/\_\_\_/\_\_\_ Obtained: \_\_\_/\_\_\_/\_\_\_ Expires: \_\_\_/\_\_\_/\_\_\_

Type: Proof of Residency

- Pending Obtained by this agency

Document Dated: \_\_\_/\_\_\_/\_\_\_ Obtained: \_\_\_/\_\_\_/\_\_\_ Source: \_\_\_\_\_

Type: HIV Letter of Diagnosis

- Pending Obtained by this agency

Document Dated: \_\_\_/\_\_\_/\_\_\_ Obtained: \_\_\_/\_\_\_/\_\_\_ Source: \_\_\_\_\_

Type: Proof of Income

- Pending Obtained by this agency

Document Dated: \_\_\_/\_\_\_/\_\_\_ Obtained: \_\_\_/\_\_\_/\_\_\_ Source: \_\_\_\_\_

**HIV DIAGNOSIS - Tab: Medical – Basic Medical**

**CDC Disease Stage:**

- HIV negative
- HIV positive, disease stage unknown
- HIV positive, asymptomatic
- HIV positive, symptomatic, not AIDS
- HIV positive, disabling
- AIDS
- Disabling AIDS
- Pediatric Indeterminate
- Unreported
- Unknown

**Source:**

- Letter of diagnosis
- Medical records (Medical providers only)
- Awaiting letter of diagnosis
- Not Applicable

**HIV AFFECTED SERVICE TYPE – Tab: Living situation for affected client**

What type of service has the client received AT YOUR AGENCY in the past 12 months?

- HIV services only
- Affected services only (See Living situation tab for Affected clients data fields)
- Both affected and HIV services
- Neither affected nor HIV services

**Note: an eligible "HIV-affected" client is the partner, family member, or other caregiver of an HIV-positive client, where both the HIV-affected client and the HIV-positive client receive services at your agency. HIV-affected clients are eligible under Ryan White to receive certain services such as caregiver training and caregiver support.**

**CLIENT CHARACTERISTICS – Tab: Demographics – Contact Info, Demographic Detail, Living Situation & Agency Specifics**

Residence Address Since  
Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Street 1 Address: \_\_\_\_\_  
City: \_\_\_\_\_

ZIP  
Code: \_\_\_\_\_ State \_\_\_\_\_  
County: \_\_\_\_\_

Phone 1: \_\_\_\_\_  
 Mobile  
 Home Phone

Phone 2: \_\_\_\_\_  
 Mobile  
 Home Phone

Email: \_\_\_\_\_

Emergency Contact Name:

Relationship to client: \_\_\_\_\_  
Street \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
Telephone 1: \_\_\_\_\_  
Telephone 2: \_\_\_\_\_

Confidential:

- Yes
- No

Message OK: \_\_\_\_Yes \_\_\_\_No

**CLIENT CHARACTERISTICS Continued – Tab: Demographics – Contact Info, Demographic Detail, Living Situation & Agency Specifics**

**Sexual Orientation:**

- Heterosexual
- Homosexual
- Lesbian
- Bisexual
- Declined to State
- Unsure
- Pediatric/Not Applicable
- Unknown

**Sex at Birth:**

- Male
- Female
- Other

**ETHNICITY – Tab: Demographics – Demographic Detail**

**What race or ethnic group do you consider yourself?**

**Hispanic:**

- Yes
- No
- Unknown

National Origin / Ethnicity (see Attachment 1):

\_\_\_\_\_

**Race:**

- White
- Black
- Asian
- American Indian/Native Alaskan
- Pacific Islander
- Other
- Unknown/Unreported

National Origin / Ethnicity (see Attachment 1):

\_\_\_\_\_

**CURRENT & PAST LIVING SITUATION – Tab: Demographics - Living Situation**

Current living situation since: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current living situation (Choose one):**

- Homeless from the streets
- Homeless from emergency shelter
- Transitional housing
- Psychiatric facility
- Substance abuse treatment facility
- Hospital or other medical facility
- Jail/Prison
- Domestic violence situation
- Living with relatives/friends
- Rental housing
- Participant-owned housing
- Board care or assisted living
- Rented room
- Refused to answer
- Other
- Unknown

**Stability Scale:**

Stable/Permanent  Temporary  Unstable

**HEALTH CARE - Tab: Medical – Basic Medical**

**Primary Medical Care (select one):**

- Alternative/Complementary Care
- County Hospital and DPH Clinics
- Community-Based Clinics, Public
- Community-Based Clinics, Private
- HMO Hospital/Clinics (e.g., Kaiser)
- VA Hospital, CHAMPUS
- Federally Qualified Health Center/Hospital
- Private MD
- Emergency Room
- No Primary Care
- Other
- Unknown

**INCOME/INSURANCE – Tab: Eligibility – Financial & Insurance**

Monthly Household Income: \_\_\_\_\_ # of People in Household: \_\_\_\_\_  
Source of Income: \_\_\_\_\_ (i.e., SSI, VA, Disability, Employment, etc)



**INSURANCE Continued– Tab: Eligibility – Financial & Insurance**

**Insurance Source:**

- ADAP
- Covered CA/ACA
- Indian Health Services
- Public 1
- Public 2
- Private 1
- Private 2
- Private 3
- Vision
- Dental
- Medi-Cal/Medicaid
- Veteran
- Other Military
- SCHIP
- Tricare
- Medicare
- Other Public Insurance
- Other
- Unknown
- No Insurance

**Insurance Type:**

- Full Scope
- Shared Cost
- Managed
- Restricted
- Baby
- CA Children Services
- DentiCAL
- Medi-Cal Expansion
- Medi-Care A
- Medi-Care A & B
- Medi-Care D
- Veterans
- County Sponsored
- CMSP
- CHAMPUS
- Family Medical Leave Act
- Pending
- COBRA
- Cobra-Family
- Cobra-Individual
- Covered CA-bronze
- Covered CA-Gold
- Covered CA-Platinum
- Covered CA-Silver
- HIPIC
- Conversion (RX)
- Private Self-Pay
- Individual Self-Pay
- Family Self-Pay
- North Star
- CHIPPS
- Other
- Unknown
- No Insurance

**Start Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm dd yy

**End Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm dd yy

**Payer:** O Client, O Employer, O Other Public, O Other

## Level II Agencies Data Requirements (In addition to Level I)

**SA & MENTAL ILLNESS – Tab: Risk & Assessments – Substance Abuse & Mental Health**  
(Note: SA & Mental Illness information is not shared across agencies even for Share clients)

**Substance Abuse Treatment**

**Treatment Status:**

- |  |  |
|--|--|
| <input type="checkbox"/> In Treatment                      | <input type="checkbox"/> Resumed Treatment |
| <input type="checkbox"/> Waiting List for Treatment        | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Refused Treatment                 | <input type="checkbox"/> Unknown           |
| <input type="checkbox"/> Completed Treatment               | <input type="checkbox"/> Not Applicable    |
| <input type="checkbox"/> Pre-Treatment Process             |  |
| <input type="checkbox"/> Dropped Out of Treatment          |  |
| <input type="checkbox"/> No Active Treatment or Counseling |  |

Treatment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mental Health Treatment**

**Treatment Status:**

- |  |  |
|--|--|
| <input type="checkbox"/> In Treatment                      | <input type="checkbox"/> Resumed Treatment |
| <input type="checkbox"/> Waiting List for Treatment        | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Refused Treatment                 | <input type="checkbox"/> Unknown           |
| <input type="checkbox"/> Completed Treatment               | <input type="checkbox"/> Not Applicable    |
| <input type="checkbox"/> Pre-Treatment Process             |  |
| <input type="checkbox"/> Dropped Out of Treatment          |  |
| <input type="checkbox"/> No Active Treatment or Counseling |  |

Treatment Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

**FIRST HIV +/AIDS Year – Tab: Medical – Basic Medical**

Date First HIV+: \_\_\_\_/\_\_\_\_/\_\_\_\_

AIDS Diag. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Year First HIV+: \_\_\_\_\_

County: \_\_\_\_\_

State: \_\_\_\_\_

Source: \_\_\_\_\_

**EXPOSURE – Tab: Risk & Assessment – Risk Factors**

**O Pediatric**

**What behaviors did the client engage in prior to his/her first HIV positive test result? Check all that apply.**

- Sex with Male
- Sex with Female
- Injected Nonprescription Drugs
- Received Clotting Factor for Hemophilia/Coagulation Disorder
- Received Transfusion of Blood/Blood Components (other than clotting factor), Transplant of Tissue/Organs or Artificial Insemination
- Worked in Healthcare or Clinical Lab Setting
- Mother HIV Infected/Perinatal Transmission
- Sexual Abuse (Pediatric Only)
- Other
- Unknown

**Sex Partner Risk Factors, Heterosexual Contact ONLY**

- Intravenous/Injection Drug User
- Bisexual Male
- Person with AIDS or Documented HIV
- Other (Person with Hemophilia/Coagulation Disorder, Transfusion Recipient with Documented HIV Infection, Transplant Recipient with Documented HIV Infection)
- Unknown

**Primary HIV Exposure**

- Men Who Have Sex with Men (MSM)
- Injection Drug User (IDU)
- Men Who Have Sex with Men and Injection Drug User (MSM and IDU)
- Hemophilia/Coagulation Disorder
- Heterosexual Contact with an At-Risk or Infected Partner
- Receipt of Transfusion of Blood, Blood Components or tissue
- Mother HIV Infected/Perinatal Transmission
- Sexual Abuse (Pediatric Only)
- Other
- Undetermined
- Risk not Reported
- Unknown

**Secondary HIV Exposure**

- Men Who Have Sex with Men (MSM)
- Injection Drug User (IDU)
- Men Who Have Sex with Men and Injection Drug User (MSM and IDU)
- Hemophilia/Coagulation Disorder
- Heterosexual Contact with an At-Risk or Infected Partner
- Receipt of Transfusion of Blood, Blood Components or Tissue
- Mother HIV Infected/Perinatal Transmission
- Sexual Abuse (Pediatric Only)
- Other
- Undetermined
- Risk not Reported
- Unknown

**EXPOSURE – Tab: Risk & Assessment –Risk Assessment**

**CD4 & Viral Load Tests – Tab: Medical - Medical History**

CD4 Date: \_\_\_/\_\_\_/\_\_\_  
 T Cell Count: \_\_\_\_\_  
 %: \_\_\_\_\_

Viral Load Date: \_\_\_/\_\_\_/\_\_\_  
 =  
 >  
 <  
 Value: \_\_\_\_\_

**HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)– Tab: Medications - ART**

**ART Type:**

- Highly Active Anti-Retroviral Therapy (HAART) (Triple Therapy)
- Combination Anti-Retrovirals but not HAART (Dual Therapy)
- Mono Therapy
- Salvage Therapy
- None/Not Applicable
- Unknown/Unreported

**Start Date:** \_\_\_/\_\_\_/\_\_\_

**End Date:** \_\_\_/\_\_\_/\_\_\_

**Anti-Retroviral Drugs (See Attachment 2 – Collect up to 4 ART Medications on this form.):**

ART 1:

\_\_\_\_\_

\_\_\_\_\_

Start Date: \_\_\_/\_\_\_/\_\_\_

End Date: \_\_\_/\_\_\_/\_\_\_

ART 3:

\_\_\_\_\_

\_\_\_\_\_

Start Date: \_\_\_/\_\_\_/\_\_\_

End Date: \_\_\_/\_\_\_/\_\_\_

ART 2:

\_\_\_\_\_

\_\_\_\_\_

Start Date: \_\_\_/\_\_\_/\_\_\_

End Date: \_\_\_/\_\_\_/\_\_\_

ART 4:

\_\_\_\_\_

\_\_\_\_\_

Start Date: \_\_\_/\_\_\_/\_\_\_

End Date: \_\_\_/\_\_\_/\_\_\_

**Adherence**

In the last three days, not including today, how many days did you take your ART medications at the times and in the amounts prescribed by your doctor?

Days:

- 0
- 1
- 2
- 3

As of Date: \_\_\_/\_\_\_/\_\_\_

**Adherence to HIV Treatment for the past four weeks:**

- Never Missed a Pill (100% of doses taken)
- Almost all of the Time (>95%, more than 19 or 20 doses taken)
- Most of the Time (80% to 95%)
- Usually (60% - 80%)
- About Half of the Time (40%-60% - approximately half of the doses taken)
- Some of the Time (20%-40%)

**Other Medications: Tab: Medications – Other Medications**

Other Medications Name \_\_\_\_\_ Used For: \_\_\_\_\_ Type: \_\_\_\_\_ Start Date: \_\_\_/\_\_\_/\_\_\_

End Date: \_\_\_/\_\_\_/\_\_\_



### Level III Agencies Data Requirements (In addition to Level I & II)

**AIDS DEFINING CONDITIONS - Tab: Medical – Basic Medical**

**AIDS Defining Conditions:**

<input type="checkbox"/> Bacterial Infections, Multiple or Recurrent (<13 only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Candidiasis, Bronchi, Trachea, or Lungs	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Candidiasis, Esophageal	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Carcinoma, Invasive Cervical (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Coccidioidomycosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Cryptococcosis, Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Cryptosporidiosis, Chronic Intestinal (>1 month duration)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Cytomegalovirus Disease (other than in liver, spleen, or nodes)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Cytomegalovirus Retinitis (with loss of vision)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> HIV Encephalopathy	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Herpes Simplex: Ulcers (>1 month); Bronchitis/ Pneumonitis/ Esophagitis	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Histoplasmosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Isosporiasis, Chronic Intestinal (>1 month duration)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Kaposi’s Sarcoma	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Lymph Interstitial Pneumonia, Pulmonary Hyperplasia (<13 only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Lymphoma, Burkitt’s (or equivalent term)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Lymphoma, Immunoblastic (or equivalent term)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Lymphoma, Primary in Brain	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> MAC or M. Kansasii, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> M. Tuberculosis, Pulmonary (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> M. Tuberculosis, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Mycobacterium of Other/Unknown Species, Disseminated or Extrapulmonary	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Pneumocystis Carinii Pneumonia	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Pneumonia, Recurrent in 12-Month Period (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Progressive Multifocal Leukoencephalopathy	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="checkbox"/> Salmonella Septicemia, Recurrent (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___

<input type="radio"/> Toxoplasmosis of Brain	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="radio"/> Wasting Syndrome due to HIV	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
<input type="radio"/> Other Diagnosis: _____	Diagnosis Date: ___/___/___ Tx Date: ___/___/___

**TUBERCULOSIS (TB) - Tab: Medical - Medical History**

**TB Test Type:**

- PPD
- Chest X-Ray
- IGRA

**TB Test Date:** \_\_\_/\_\_\_/\_\_\_

**TB Test Outcome:**

- Is not medically indicated \_\_\_
- Lost to follow-up \_\_\_
- Negative \_\_\_
- Non-reactive \_\_\_
- Positive \_\_\_
- Reactive \_\_\_
- Unknown \_\_\_

**Outcome Date:** \_\_\_/\_\_\_/\_\_\_

**STI SCREENING/TREATMENT - Tab: Medical - Medical History**

**STI / Hepatitis:**

- Genital Herpes
- Gonorrhea
- Human Papillomavirus (Genital Warts)
- Syphilis
- Non-Specific Urethritis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Chlamydia

- Indeterminate
- Unknown

**Lab Value:** \_\_\_\_\_

**Treatment Indicated:**

- Yes
- No
- Patient Refused

**Treatment Start Date:** \_\_\_/\_\_\_/\_\_\_

**Treatment End Date:** \_\_\_/\_\_\_/\_\_\_

**Test Date:** \_\_\_/\_\_\_/\_\_\_

**Outcome:**

- Completed
- Not Completed
- Unknown
- Not Applicable

**Diagnosis:**

- Negative Diagnosis
- Positive Diagnosis
- Presumptive

**IMMUNIZATION TYPE AND DATE: Tab: Medical- Medical History**

Immunization Type:

- BCG  Flu  Hepatitis B Dose 1  Hepatitis B Dose 2  Hepatitis B Dose 3  PCP  Pneumovax  Tetanus  Other

Date: \_\_\_/\_\_\_/\_\_\_  Is not medically indicated

**OB/GYN – Tab: Medical – OB/GYN & Pregnancy**

**Primary OB/GYN:**  
\_\_\_\_\_

**Pap Smear & Pelvic Exam Date:** \_\_\_/\_\_\_/\_\_\_

**Result:** \_\_\_\_\_

**Pregnancy History**

**Date First Reported Pregnant:** \_\_\_/\_\_\_/\_\_\_

**Estimated Date of Conception:** \_\_\_/\_\_\_/\_\_\_

**HIV Status during Pregnancy:**

- HIV Positive after Conception
- HIV Positive Prior to Pregnancy

**Date Prenatal Care Began:** \_\_\_/\_\_\_/\_\_\_

**# of Prenatal Visits in Reporting Month:** \_\_\_\_\_

**ART Counseling Offered to Reduce HIV Transmission to Infant:**

- Yes
- No
- Unknown

**Date Received ART Counseling:** \_\_\_/\_\_\_/\_\_\_

**ART Was Offered to Reduce Vertical Transmission to Infant:**

- Yes
- No
- Unknown

**Date ART Was Taken:** \_\_\_/\_\_\_/\_\_\_

**Pregnancy Outcome:**

- Live Birth
- Therapeutic (Induced) Abortion
- Spontaneous Abortion (Miscarriage)
- Stillbirth
- Unknown

**Date of Pregnancy Outcome:** \_\_\_/\_\_\_/\_\_\_

**Newborn HIV Status:**

- Positive
- Negative
- Indeterminate
- Unknown