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: **HIV Letter of Diagnosis**

- ☐ **Pending**
- ☐ Obtained by this agency

Document Dated: ___/___/___
Obtained: ___/___/___

Source: _____

Type: **Proof of Residency**

- ☐ **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:

- O Letter of diagnosis
- O Medical records (Medical providers only)
- O Awaiting letter of diagnosis
- O 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:
O Male O Female O Other

ETHNICITY – Tab: Demographics – Demographic Detail

What race or ethnic group do you consider yourself?

Hispanic:

☐ Yes No Unknown

National Origin / Ethnicity

_____

Race:

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

National Origin / Ethnicity

_____

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:

O Stable/Permanent O Temporary O 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
- O Medi-Cal/Medicaid
- O Veteran
- O Other Military
- O SCHIP
- O Tricare
- O Medicare
- O Other Public Insurance
- O Other
- O Unknown
- O 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
- O COBRA
- O Cobra-Family
- O Cobra-Individual
- O Covered CA-bronze
- O Covered CA-Gold
- O Covered CA-Platinum
- O Covered CA-Silver
- O HIPIC
- O Conversion (RX)
- O Private Self-Pay
- O Individual Self-Pay
- O Family Self-Pay
- O North Star
- O CHIPPS
- O Other
- O Unknown
- O 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)

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

Date First HIV+: ___/___/___

Year First HIV+: _____

If applicable -AIDS Diag. Date: ___/___/___

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.

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

Sex Partner Risk Factors, Heterosexual Contact ONLY
O Intravenous/Injection Drug User
O Bisexual Male
O Person with AIDS or Documented HIV
O Other (Person with Hemophilia/Coagulation Disorder, Transfusion Recipient with Documented HIV Infection, Transplant Recipient with Documented HIV Infection)
O Unknown

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

EXPOSURE – Tab: Risk & Assessment –Risk Assessment

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

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

CD4 Date: ___/___/___
T Cell Count: _____
%: _____

Viral Load Date: ___/___/___
O =
O >
O <
Value: _____

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

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

Start Date: ___/___/___

End Date: ___/___/___

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:

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

O Salmonella Septicemia, Recurrent (Adult Only)	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
O Toxoplasmosis of Brain	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
O Wasting Syndrome due to HIV	Diagnosis Date: ___/___/___ Tx Date: ___/___/___
O Other Diagnosis:_____	Diagnosis Date: ___/___/___ Tx Date: ___/___/___

STI SCREENING/TREATMENT - Tab: Medical - Medical History

STI / Hepatitis:
O Genital Herpes
O Gonorrhea
O Human Papillomavirus (Genital Warts)
O Syphilis
O Non-Specific Urethritis
O Hepatitis A
O Hepatitis C
O Chlamydia

Test Date: ___/___/___

Diagnosis:
O Negative Diagnosis
O Positive Diagnosis
O Presumptive
O Indeterminate
O Unknown

Lab Value: _____

Treatment Indicated:
O Yes
O No
O Patient Refused

Treatment Start Date: ___/___/___

Treatment End Date: ___/___/___

Outcome:
O Completed
O Not Completed
O Unknown
O Not Applicable

IMMUNIZATION TYPE AND DATE: Tab: Medical- Medical History

Immunization Type:

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

Date:__/____/_____ O Is not medically indicated

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

Primary OB/GYN:

_____

HIV Status during Pregnancy:
O HIV Positive Prior to Pregnancy
O HIV Positive after Conception

Pregnancy History:

Date First Reported Pregnant: ___/___/___
Estimated Date of Conception:___/___/___
HIV Status during Pregnancy: ___/___/___

ART Counseling Offered to Reduce HIV Transmission to Infant:
O Yes
O No
O Unknown

Date Received ART Counseling: ___/___/___

ART Was Offered to Reduce Vertical Transmission to Infant:
O Yes
O No
O Unknown

Date ART Was Taken: ___/___/___

Pregnancy Outcome:
O Live Birth
O Therapeutic (Induced) Abortion
O Spontaneous Abortion (Miscarriage)
O Stillbirth
O Unknown

Date of Pregnancy Outcome: ___/___/___

Newborn HIV Status:
O Positive O Negative O Indeterminate O Unknown