

# الجمهورية اللبنانية

وزارة الصحة العامة  
البرنامج الوطني لمكافحة السيدا في لبنان



منظمة  
الصحة العالمية



الجمهورية اللبنانية  
وزارة الصحة العامة



## قسمة ابلاغ حالات السيدا

اسم المريض:	اسم الأب:	اسم الأم:
تاريخ الولادة: ____/____/____ يوم شهر سنة	الجنس: ذكر <input type="checkbox"/> أنثى <input type="checkbox"/>	
الجنسية:	العنوان: البلدة	القضاء
الوضع الاجتماعي:	متزوج <input type="checkbox"/> أعزب <input type="checkbox"/> مطلق <input type="checkbox"/> أرمل <input type="checkbox"/>	
المستوى التعليمي:	ابتدائي <input type="checkbox"/> ثانوي <input type="checkbox"/> جامعي <input type="checkbox"/> أمي <input type="checkbox"/>	
المهنة:		

### Instructions

The treating physician is kindly asked to fill this form as accurately and completely as possible. Information confidentiality is guaranteed. Return the forms as soon as possible to the National AIDS Program in the sealed envelope.

### (Instructions)

Le medecin traitant est prie de remplir le format, le plus completent et exactement possible. La confidentialite de l'information incluse est garantie. Envoyer les fiches le plus tot possible au Programme Nationale de Lutte contre le SIDA dans l'enveloppe fermee.

### Reason for Testing / (Raison du Test)

- |  |  |
|--|--|
| <input type="checkbox"/> Voluntary / (Volontaire)            | <input type="checkbox"/> Clinical Suspicion / (Suspicion Clinique) |
| <input type="checkbox"/> Blood Donation / (Donation de Sang) | <input type="checkbox"/> Premarital / (Prenuptial)                 |
| <input type="checkbox"/> Routine pre-op / (Routine pre-op)   | <input type="checkbox"/> Visa/Work / (Visa/Travail)                |
| <input type="checkbox"/> Others / (Autres) -----             |  |

### Reserved to the National Prog. (Reserve au Programme National)

Serial No.: \_\_\_\_\_

File No.: \_\_\_\_\_

### Type of Test / (Type de Test)

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Rapid / (Rapide)        | <input type="checkbox"/> ELISA / (ELISA) | <input type="checkbox"/> WB / (WB) |
| <input type="checkbox"/> Others / (Autres) ----- |  |                                    |

### Testing Date / (Date du Test)

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### Symptoms Codes

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### Family Members Tests / (Tests des Membres de la Famille)

- |   |                              |                              |            |
|---|------------------------------|------------------------------|------------|
| Spouse / (Epoux / epouse)                         | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Date ----- |
| Children / (Enfants) (1)                          | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Date ----- |
| (2)   | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Date ----- |
| (3)   | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Date ----- |
| Other Sexual Contacts / (Autres Contacts Sexuels) | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | Date ----- |

### STD Code

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Reserved to the National Prog. (Reserve au Programme National)	Symptoms Codes	STD Code
Serial No.: -----	-----	-----
File No.: -----	-----	-----

### Risk Factors / (Facteurs de Risques)

- a - Sexual behavior / (Comportement Sexuel) Homosexual/(Homosexuel) Bisexual/(Bisexuel) Heterosexual/(Heterosexuel) None/(Aucun)
- b - Multiple Partners / (Partenaires Multiples) ☐ Yes / (Oui) ☐ No / (Non)  
If yes, specify -----  
(Si oui, specifier) -----
- c - Sexually Transmitted Diseases / (Maladies Sexuellement Transmissibles) ☐ Yes / (Oui) ☐ No / (Non)  
If yes, specify -----  
(Si oui, specifier) -----
- d - Multiple Transfusions / (Transfusions multiples) ☐ Yes / (Oui) ☐ No / (Non)  
If yes, specify reason -----  
(Si oui, specifier cause) -----
- e - Recent Travel / (Voyages Recents) ☐ Yes / (Oui) ☐ No / (Non) ☐ Country / (Pays) -----

### Probable way of transmission / (Voie de transmission probable)

- Sexual / (Sexuelle) ☐ Yes / (Oui) ☐ No / (Non)
- IVDU (Droque par voie IV) ☐ Yes / (Oui) ☐ No / (Non)
- Contaminated Instruments / (Instruments Contamines) ☐ Yes / (Oui) ☐ No / (Non)
- Transfusion / (Transfusion) ☐ Yes / (Oui) ☐ No / (Non)  
If yes, specify / (Si oui, specifier) Year / (Annee) ----- Country / (Pays) -----
- Perinatal Transmission / (Transmission Perinatale) ☐ Yes / (Oui) ☐ No / (Non)

### Clinical Manifestations / (Manifestations Cliniques)

- ☐ Asymptomatic / (Asymptomatique)
- ☐ Fever (> 1 month, intermittent or constant) / (Fievre, 1 mois intermittente ou constante)
- ☐ Weight loss (>10% body weight) / (Perte de Poids, >10% du poids)
- ☐ Cryptococcal meningitis / (Meningite a cryptocoques)
- ☐ Tuberculosis (Pulmonary or extra-pulmonary) / (Tuberculose, pulmonaire ou extra pulmonaire)
- ☐ Diarrhea (> 1 month, constant or intermittent) / (Diarrhee, > 1 mois, constante ou intermittente)
- ☐ Toxoplasmosis / (Toxoplasmose)
- ☐ Kaposi Sarcoma / (Sarcome de Kaposi)
- ☐ Candidiasis of the oesophagus / (Candidose de l'oesophage)
- ☐ Invasive Cervical cancer / (Cancer Invasif du col de l'uterus)
- ☐ Generalized lymphadenopathy / (Adinopathie generalisee)
- ☐ Generalized pruritic dermatitis / (Dermatite prurigineuse generalizee)
- ☐ Recurrent Pneumonia / (Pneumonies repetees)
- ☐ Sexually transmitted diseases, Specify / (Maladies Sexuellements transmissibles, Specifier): -----  
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- ☐ Others, Specify / (Autres, Specifier):-----  
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### Physician / (Medecin)

Name / (Nom) -----

Address / (Adresse) -----  
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Phone / (Tel) -----  
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### Date of Reporting / (Date de declaration)

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Signature, Stamp  
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