Patient Identification

*Patient Name *First Name	*Middle Name	*Last Name	Last Name Soundex

*Alternate Name Type (ex Birth, Call Me)	*First Name	*Middle Name	*Last Name

Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Street Address	*Phone ( ) _____

City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type:	Number:

U.S. Department of Health & Human Services

Pediatric HIV Confidential Case Report Form

(Patients <13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control and Prevention

Health Department Use Only

Form approved OMB no 0920-0573 Exp. 01/31/2013

Date Received at Health Department __ __ /__ __ /__ __ __ __	eHARS Document UID _____	State Number _____

Reporting Health Dept - City / County	City/County Number

Document Source _____	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown

Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 6-CD/Disk

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name	*Phone ( ) _____

*Street Address

City	County	State/Country	Zip Code

Facility Type — *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____ *Other Facility:* ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____

Date Form Completed __ __ /__ __ /__ __ __ __	*Person Completing Form	*Phone ( ) _____

Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report ☐ 3-Perinatal HIV Exposure ☐ 4-Pediatric HIV ☐ 5-Pediatric AIDS ☐ 6-Pediatric Seroreverter	Sex assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/ US Dependency (please specify) _____

Date of Birth __ __ /__ __ /__ __ __ __	Alias Date of Birth __ __ /__ __ /__ __ __ __

Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __ /__ __ /__ __ __ __	State of Death _____

Date of Last Medical Evaluation __ __ /__ __ /__ __ __ __	Date of Initial Evaluation for HIV __ __ /__ __ /__ __ __ __

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	*ExpandedEthnicity _____

Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown	*Expanded Race _____

Residence at Diagnosis (add additional addresses in Comments)

Address Type (Check all that apply to address below)	☐ Residence at HIV diagnosis	☐ Residence at AIDS diagnosis	☐ Residence at Perinatal Exposure	☐ Residence at Pediatric Seroreverter	☐ Check if SAME as Current Address

* Street Address

City	County	State/Country	*ZIP Code

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

STATE/LOCAL USE ONLY	– Patient identifier information is not transmitted to CDC! –

Physician's Name: (Last, First, M.I.) Medical Record

_____ Phone No: ( ) _____ No._____

Hospital/Facility: Person Completing Form:

_____ _____ Phone No: ( ) _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type ☐ HIV ☐ AIDS ☐ Perinatal Exposure (check all that apply to facility below) ☐ Check if SAME as Facility Providing Information

Facility Name	***Phone** ( ) _____
***Street Address**	

City	**County**	**State/Country**	**Zip Code**

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____ *Other Facility:* ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____

***Provider Name**	***Provider Phone** ( ) _____	***Specialty**

Patient History (resond to all questions) record all dates as mm/dd/yyyy)

Child's biological mother's HIV infection status (select one): ☐ 1-Refused HIV testing ☐ 2-Known to be uninfected after this child's birth ☐ 3-Known HIV+ before pregnancy ☐ 4-Known HIV+ during pregnancy ☐ 5-Known HIV+ sometime before birth ☐ 6-Known HIV+ at delivery ☐ 7-Known HIV+ after child's birth ☐ 8-HIV+, time of diagnosis unknown ☐ 9-HIV status unknown

Date of mother's first positive HIV confirmatory test: __ __ / __ __ / __ __ __ __	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? ☐ Yes ☐ No ☐ Unknown

After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV Infection	☐ Yes ☐ No ☐ Unknown
Injected drugs not prescribed for patient	☐ Yes ☐ No ☐ Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with AIDS or documented HIV Infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section) First date received ___ ___ / ___ ___ / ___ ___ ___ ___ Last date received ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Before the diagnosis of HIV infection, this child had:	
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder — Specify clotting factor: Date received (mm/ dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section) First date received ___ ___ / ___ ___ / ___ ___ ___ ___ Last date received ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Other Documented Risk (please include detail in Comments section)	☐ Yes ☐ No ☐ Unknown

Laboratory Data (record additional tests in Comments section)

HIV Antibody Tests (Non-type differentiating) [HIV-1 vs. HIV-2]

TEST 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB ☐ Other: Specify Test: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** (*check if rapid*): ☐ **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB ☐ Other: Specify Test: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** (*check if rapid*): ☐ **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Antibody Tests (Type differentiating) [HIV-1 vs. HIV-2]

TEST: ☐ HIV-1/2 Differentiating (e.g., Multispot)

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test after diagnosis

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to current diagnostic status: CD4 count: _____cells/μL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

First CD4 result <200 cells/μL or <14%: CD4 count: _____cells/μL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Documentation of Tests

If laboratory tests were not documented, is patient confirmed by a physician as:

HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of Documentation:** __ __ /__ __ /__ __ __ __

Not HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of Documentation:** __ __ /__ __ /__ __ __ __

Clinical (select D for Definitive or P for Presumptive where applicable) (record all dates as mm/dd/yyyy)

	D	P	Date		D	P	Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)				Kaposi's sarcoma			
Candidiasis, bronchi, trachea, or lungs				Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia			
Candidiasis, esophageal				Lymphoma, Burkitt's (or equivalent)			
Coccidiodomycosis, disseminated or extrapulmonary				Lymphoma, immunoblastic (or equivalent)			
Cryptococcosis, extrapulmonary				Lymphoma, primary in brain			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary			
Cytomegalovirus disease (other than in liver, spleen, or nodes)				M. tuberculosis, disseminated or extrapulmonary†			
Cytomegalovirus retinitis (with loss of vision)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
HIV encephalopathy				Pneumocystis pneumonia			
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				Progressive multifocal leukoencephalopathy			
Histoplasmosis, disseminated or extrapulmonary				Toxoplasmosis of brain, onset at >1 mo. of age			
Isosporiasis, chronic intestinal (>1 mo. duration)				Wasting syndrome due to HIV			

Has this child been diagnosed with pulmonary tuberculosis? ☐ Yes ☐ No ☐ Unknown

If **Yes**, initial diagnosis: ☐ Definitive ☐ Presumptive ☐ Unknown

Date:

†If TB selected above, indicate RVCT Case Number:

Birth History (for Perinatal Cases only)

Birth History Available ☐ Yes ☐ No ☐ Unknown | **Residence at Birth** ☐ Check if SAME as Current Address

*** Street Address** | **City**

County | **State/Country** | ***Zip Code**

Hospital of Birth

☐ Check if SAME as Facility Providing Information

Facility Name | ***Phone** ( ) _____ | **Zip Code**

***Street Address** | **City** | **County** | **State/Country**

Birth History

Birth Weight _____ lbs _____ oz _____ grams

Type ☐ 1-Single ☐ 2-Twin ☐ 3->2 ☐ 9-Unknown

Delivery ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Non-Elective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown

Birth Defects ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ Unknown

Neonatal Status Weeks: _____ (99–Unknown)

Prenatal Care – Month of Pregnancy Prenatal Care began _____ (00-None, 99-Unknown)

Prenatal Care - Total number of prenatal care visits: _____ (00-None, 99-Unknown)

Did mother receive zidovudine (ZDV,AZT) during pregnancy: ☐ Yes ☐ No ☐ Refused ☐ Unknown

If yes, what week of pregnancy was zidovudine (ZDV, AZT) started: _____ (99-Unknown)

Did mother receive zidovudine (ZDV,AZT) during labor/delivery: ☐ Yes ☐ No ☐ Refused ☐ Unknown

Did mother receive zidovudine (ZDV,AZT) prior to this pregnancy: ☐ Yes ☐ No ☐ Unknown

Did mother receive any other Anti-retroviral medication during pregnancy? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

Did mother receive any other Anti-retroviral medication during labor/delivery? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

Maternal Information

Maternal DOB | **Maternal Soundex** | **Maternal Stateno** | **Maternal Country of Birth**

***Other Maternal ID – List Type:** **Number:**

Services Referrals (record all dates as mm/dd/yyyy)

This child received or is receiving:

Neonatal zidovudine (ZDV,AZT) for HIV prevention: ☐ Yes ☐ No ☐ Unknown **Date:** __ __/__ __/__ __ __ __

Other neonatal anti-retroviral medication for HIV prevention: ☐ Yes ☐ No ☐ Unknown **Date:** __ __/__ __/__ __ __ __

If Yes, please specify: 1) 2) 3) 4) 5)

Anti-retroviral therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown **Date:** __ __/__ __/__ __ __ __

PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown **Date:** __ __/__ __/__ __ __ __ | **Was this child breastfed?** ☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is: ☐ 1- Biological Parent ☐ 2- Other Relative ☐ 3- Foster/Adoptive parent, relative ☐ 4- Foster/Adoptive parent, unrelated ☐ 7- Social Service Agency ☐ 8- Other (please specify in comments) ☐ 9- Unknown

*Comments

*Local / Optional Fields