Attachment 3 (b)

National HIV Surveillance System (NHSS)

OMB # 0920-0573

Pediatric HIV Confidential Case Report Form

Form Approved
OMB No. 0920-0573
Expiration Date XX/XX/XXXX

Pediatric HIV Confidential Case Reports for the National HIV Surveillance System (NHSS)

Pediatric HIV Confidential Case Report Form

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: PRA (0920-0573)

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	*Current Street Address	*Phone ( ) _____

City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type:	Number:

Pediatric HIV Confidential Case Report Form

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

Form approved OMB no 0920-0573 Exp. XX/XX/XXXX

Health Department Use Only

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 No.

_____ Phone No: ( ) _____ _____

Hospital/Facility: Person Completing Form:

_____ _____

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 (respond 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 non-prescription drugs	☐ 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 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) (record all dates as mm/dd/yyyy)

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**: ____/____/____

Manufacturer: _____

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**: ____/____/____

Manufacturer: _____

TEST 3: ☐ 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**: ____/____/____

Manufacturer: _____

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**: ____/____/____

Other CD4 result: CD4 count: _____cells/µL **CD4 percentage**: _____% **Collection Date**: ____/____/____

Documentation of Tests

Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]:

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown

If YES, provide date of earliest positive test for this algorithm (specimen collection date if known): ____/____/____

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 (record all dates as mm/dd/yyyy)

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

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 Gestational Age in Weeks:** ___(99–Unknown)

Gestational Month Prenatal Care began _____ (00-None, 99-Unknown) | **Prenatal Care - Total number of prenatal care visits:** _____ (00-None, 99-Unknown)

Did mother receive any Anti-retrovirals (ARVs) prior to this pregnancy: ☐ Yes ☐ No ☐ Refused ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during pregnancy: ☐ Yes ☐ No ☐ Refused ☐ Unknown | **If yes, please Specify all:**

Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

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 ARVs 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