

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 <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> 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 <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Report Medium <input type="checkbox"/> 1-Field Visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic Transfer <input type="checkbox"/> 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	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____ <i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Other, specify _____ <i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____		
Date Form Completed ____/____/____	*Person Completing Form _____	*Phone () _____	

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

Diagnostic Status at Report <input type="checkbox"/> 3-Perinatal HIV Exposure <input type="checkbox"/> 4-Pediatric HIV <input type="checkbox"/> 5-Pediatric AIDS <input type="checkbox"/> 6-Pediatric Seroreverter	Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/ US Dependency (please specify) _____
Date of Birth ____/____/____	Alias Date of Birth ____/____/____	
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead	Date of Death ____/____/____	State of Death _____
Date of Last Medical Evaluation ____/____/____	Date of Initial Evaluation for HIV ____/____/____	
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	*Expanded Ethnicity _____	
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	*Expanded Race _____	

Residence at Diagnosis (add additional addresses in Comments)

Address Type (Check all that apply to address below)	<input type="checkbox"/> Residence at HIV diagnosis	<input type="checkbox"/> Residence at AIDS diagnosis	<input type="checkbox"/> Residence at Perinatal Exposure	<input type="checkbox"/> Residence at Pediatric Seroreverter	<input type="checkbox"/> Check if <u>SAME</u> as <u>Current Address</u>
* 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: _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Perinatal Exposure (check all that apply to facility below)		<input type="checkbox"/> Check if <u>SAME</u> as Facility Providing Information	
Facility Name		*Phone () _____	
*Street Address			
City	County	State/Country	Zip Code
Facility Type	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> 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): <input type="checkbox"/> 1-Refused HIV testing <input type="checkbox"/> 2-Known to be uninfected after this child's birth <input type="checkbox"/> 3-Known HIV+ before pregnancy <input type="checkbox"/> 4-Known HIV+ during pregnancy <input type="checkbox"/> 5-Known HIV+ sometime before birth <input type="checkbox"/> 6-Known HIV+ at delivery <input type="checkbox"/> 7-Known HIV+ after child's birth <input type="checkbox"/> 8-HIV+, time of diagnosis unknown <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV Infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Before the diagnosis of HIV infection, this child had:	
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/ coagulation disorder	Specify clotting factor: Date received (mm/ dd/yyyy): ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other Documented Risk (please include detail in Comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: _____/_____/_____			
Manufacturer: _____			
TEST 2: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: _____/_____/_____			
Manufacturer: _____			
TEST 3: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other: Specify Test: _____			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate RAPID TEST (check if rapid): <input type="checkbox"/> Collection Date: _____/_____/_____			
Manufacturer: _____			
HIV Antibody Tests (Type-differentiating) [HIV-1 vs. HIV-2]			
TEST: <input type="checkbox"/> HIV-1/2 Differentiating (e.g., Multispot)			
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) Collection Date: _____/_____/_____			
HIV Detection Tests (Qualitative)			
TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: _____/_____/_____			
TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: _____/_____/_____			
HIV Detection Tests (Quantitative viral load) Note: Include earliest test after diagnosis			
TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load)			
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: _____/_____/_____			
TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load)			
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: _____/_____/_____			
Immunologic Tests (CD4 count and percentage)			
CD4 at or closest to current diagnostic status: CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: _____/_____/_____			
First CD4 result <200 cells/ μ L or <14%: CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: _____/_____/_____			
Other CD4 result: CD4 count: _____ cells/ μ L 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, provide date of earliest positive test for this algorithm (specimen collection date if known): _____/_____/_____			
If laboratory tests were not documented, HIV-Infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of documentation: _____/_____/_____			
is patient confirmed by a physician as: Not HIV-Infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, initial diagnosis: <input type="checkbox"/> Definitive <input type="checkbox"/> Presumptive <input type="checkbox"/> Unknown		Date:	†If TB selected above, indicate RVCT Case Number:	

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Birth History (for Perinatal Cases only)

Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Residence at Birth <input type="checkbox"/> Check if <u>SAME</u> as Current Address	
* Street Address		City	
County	State/Country	*Zip Code	
Hospital of Birth			
<input type="checkbox"/> Check if <u>SAME</u> as Facility Providing Information			
Facility Name		*Phone () _____	Zip Code
*Street Address	City	County	State/Country
Birth History			
Birth Weight _____lbs _____oz _____grams		Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3->2 <input type="checkbox"/> 9-Unknown	Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Non-Elective Cesarean <input type="checkbox"/> 4-Cesarean, unknown type <input type="checkbox"/> 9-Unknown
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, please specify:	
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, please specify all:	
Did mother receive any ARVs during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, please Specify all:	
Did mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date: ____/____/____	
If Yes, please specify: 1) _____		2) _____ 3) _____ 4) _____ 5) _____	
Anti-retroviral therapy for HIV treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date: ____/____/____	
PCP Prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date: ____/____/____	
This child's primary caretaker is: <input type="checkbox"/> 1- Biological Parent <input type="checkbox"/> 2- Other Relative <input type="checkbox"/> 3- Foster/Adoptive parent, relative <input type="checkbox"/> 4- Foster/Adoptive parent, unrelated <input type="checkbox"/> 7- Social Service Agency <input type="checkbox"/> 8- Other (please specify in comments) <input type="checkbox"/> 9- Unknown		Was this child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
*Comments			

***Local / Optional Fields**
