Attachment 3 (b)

Adult and Pediatric HIV/AIDS Confidential Case Reports
for National HIV/AIDS Surveillance OMB No. 0920-0573

Pediatric HIV/AIDS Confidential Case Report Form

Form Approved
OMB No. 0920-0573
Expiration Date XX/XX/20XX

Adult and Pediatric HIV/AIDS Confidential Case Reports
for National HIV/AIDS Surveillance

Pediatric HIV/AIDS 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-0573)

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT ***– Patient identifier information is not transmitted to CDC! –***

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients <13 years of age at time of diagnosis)

CDC Centers for Disease Control and Prevention

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 2/28/2010

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT:
State: _____
City/ County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)
3 Perinatally HIV Exposed; 4 Confirmed HIV Infection (not AIDS); 5 AIDS; 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months
HIV Infection (not AIDS) ...
AIDS .....

CURRENT STATUS: 1 Alive; 2 Dead; 9 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes 1 No 0 Unk. 9

SEX: 1 Male; 2 Female

ETHNICITY: (select one)
1 Hispanic; 2 Not Hispanic or Latino; 9 Unk.

RACE: (select one or more)
American Indian/ Alaska Native; Native Hawaiian or Other Pacific Islander; Asian; White; Black or African American; Unk

COUNTRY OF BIRTH:
1 U.S.; 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
8 Other (specify): _____; 9 Unk.

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/ Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/ Country: _____

FACILITY SETTING (check one)
1 Public; 2 Private; 3 Federal; 9 Unk.

FACILITY TYPE (check one)
01 Physician, HMO; 31 Hospital, Inpatient; 88 Other (specify): _____

V. PATIENT/MATERNAL HISTORY *(Respond to ALL categories)*

• **Child's biologic mother's HIV Infection Status:** (check one)
1 Refused HIV testing; 2 Known to be **un**infected after this child's birth; 9 HIV status unknown

Diagnosed with HIV Infection/AIDS:
3 Before this child's pregnancy; 4 During this child's pregnancy; 5 At time of delivery; 6 Before child's birth, exact period unknown; 7 After the child's birth; 8 HIV-infected, unknown when diagnosed

• **Date of mother's first positive HIV confirmatory test:** ..... Mo. Yr.

• **Mother was counseled about HIV testing during this pregnancy, labor or delivery?** ..... Yes 1 No 0 Unk. 9

After 1977, this child's biologic mother had: Yes No Unk.

- Injected nonprescription drugs 1 0 9
- *HETEROSEXUAL* relations with:
  - Intravenous/injection drug user 1 0 9
  - Bisexual male 1 0 9
  - Male with hemophilia/coagulation disorder 1 0 9
  - Transfusion recipient with documented HIV infection 1 0 9
  - Transplant recipient with documented HIV infection 1 0 9
  - Male with AIDS or documented HIV infection, risk not specified .. 1 0 9
- Received transfusion of blood/blood components (other than clotting factor) 1 0 9
- Received transplant of tissue/organs or artificial insemination 1 0 9

Before the diagnosis of HIV Infection/AIDS, this child had: Yes No Unk.

- Received clotting factor for hemophilia/coagulation disorder 1 0 9
  (specify disorder): 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____
- Received transfusion of blood/blood components (other than clotting factor) 1 0 9
  First: Mo. Yr. Last: Mo. Yr.
- Received transplant of tissue/organs 1 0 9
- Sexual contact with a male 1 0 9
- Sexual contact with a female 1 0 9
- Injected nonprescription drugs 1 0 9
- Other (Alert State/City NIR Coordinator) 1 0 9

VI. STATE/LOCAL USE ONLY

Physician's Name: (Last, First, M.I.) _____ Phone No.: ( ) _____ Medical Record No. _____

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. HIV DETECTION TESTS: (Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		

	Positive	Negative	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify _____	1	0	9		

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

	Mo.	Yr.
• CD4 Count _____ , _____ cells/µL		
• CD4 Count _____ , _____ cells/µL		
• CD4 Percent _____ %		
• CD4 Percent _____ %		

5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ..... Yes 1 No 0 Unk. 9

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

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii,* disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. *RVCT CASE NO.:

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] Unk. ***If No or Unknown, proceed to Section X.***

HOSPITAL AT BIRTH:

Hospital:_____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/ Country: _____ Zip Code: _____

BIRTHWEIGHT: (enter lbs/oz OR grams)

____ **lbs.** ____ **oz**

____ **grams**

BIRTH: **Type:** .... [1] Single [2] Twin [3] >2 [9] Unk.

Delivery: ..... [1] Vaginal [2] Elective Caesarean [3] Non-elective Caesarean [4] Caesarean, unk. type [9] Unk.

Birth Defects: .... [1] Yes [0] No [9] Unk.

Specify type(s): _____ **Code:** ____ . ____

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks ____ 99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: ____ mos. 99 = Unk. 00 = None

Total number of prenatal care visits: ____ 99 = Unk. 00 = None

- **Did mother receive zidovudine (ZDV, AZT) during pregnancy?** Refused [8] Yes [1] No [0] Unk. [9]
- **If yes, what week of pregnancy was zidovudine (ZDV, AZT) started?** Weeks: ____ 99 = Unk.
- **Did mother receive zidovudine (ZDV, AZT) during labor/delivery?** Refused [8] Yes [1] No [0] Unk. [9]
- **Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?** Yes [1] No [0] Unk. [9]
- **Did mother receive any other Anti-retroviral medication during pregnancy?** Yes [1] No [0] Unk. [9]
  If yes, specify: _____
- **Did mother receive any other Anti-retroviral medication during labor/delivery?** Yes [1] No [0] Unk. [9]
  If yes, specify: _____

Maternal Date of Birth Mo. Day Yr. ____

Maternal Soundex: ____ _____

Maternal State Patient No. ____

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

[8] Other (specify): _____ [9] Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo. Day Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	[1]	[0]	[9]	____ ____ ____
• Other neonatal anti-retroviral medication for HIV *prevention*	[1]	[0]	[9]	____ ____ ____
• Anti-retroviral therapy for HIV *treatment*	[1]	[0]	[9]	____ ____ ____
• PCP prophylaxis	[1]	[0]	[9]	____ ____ ____

If yes, specify: _____

Was child breastfed? Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial: [1] NIH-sponsored [2] Other [3] None [9] Unk.

Clinic: [1] HRSA-sponsored [2] Other [3] None [9] Unk.

This child's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO [3] No coverage [4] Other Public Funding [7] Clinical trial/government program [9] Unk.

This child's primary caretaker is:

[1] Biologic parent(s) [2] Other relative [3] Foster/Adoptive parent, relative [4] Foster/Adoptive parent, unrelated [7] Social service agency [8] Other (specify in Section XI.) [9] Unk.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

XI. COMMENTS (continued)