

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

## **National HIV Surveillance System (NHSS)**

Attachment 3b.

### **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 30329; ATTN: PRA (0920-0573).

**Patient Identification (record all dates as mm/dd/yyyy)**

*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 <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				*Current Address, Street				Address Date ____/____/____	
*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 CDCCenters for Disease Control  
and Prevention**Health Department Use Only (record all dates as mm/dd/yyyy)**

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

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 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/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown					Expanded Race _____		

**Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)**

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 as Current Address</u>							
* Street Address						Address Date ____/____/____	
City		County		State/Country		*ZIP Code	

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**STATE/LOCAL USE ONLY**

\*Provider Name (Last, First, M.I.) \_\_\_\_\_

\*Phone ( ) \_\_\_\_\_

Hospital/Facility \_\_\_\_\_

**Facility of Diagnosis (add additional facilities in Comments)**

<b>Diagnosis Type</b> (Check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Perinatal Exposure <input type="checkbox"/> Check if <u>SAME</u> as Facility Providing Information			
<b>Facility Name</b> _____		<b>*Phone</b> ( ) _____	
<b>*Street Address</b> _____			
<b>City</b> _____	<b>County</b> _____	<b>State/Country</b> _____	<b>*ZIP Code</b> _____
<b>Facility Type</b> <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 _____			
<b>*Provider Name</b> _____		<b>*Provider Phone</b> ( ) _____	<b>Specialty</b> _____

**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"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> Known HIV+ at delivery <input type="checkbox"/> Known HIV+ after child's birth <input type="checkbox"/> HIV+, time of diagnosis unknown <input type="checkbox"/> 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
<b>After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:</b>	
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
<b>Biological Mother had HETEROSEXUAL relations with any of the following:</b>	
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)	<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
<b>Before the diagnosis of HIV infection, this child had:</b>	
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: ____/____/____
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**Laboratory Data (record additional tests and tests not specified in Comments) (record all dates as mm/dd/yyyy)**

<b>HIV Immunoassays (Non-differentiating)</b>			
<b>TEST 1:</b> <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <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 IA <input type="checkbox"/> HIV-2 WB			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/_____ <input type="checkbox"/> Rapid Test (check if rapid)	
<b>TEST 2:</b> <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <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 IA <input type="checkbox"/> HIV-2 WB			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/_____ <input type="checkbox"/> Rapid Test (check if rapid)	
<b>HIV Immunoassays (Differentiating)</b>			
<input type="checkbox"/> HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/_____ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> Ag reactive <input type="checkbox"/> Ab reactive <input type="checkbox"/> Both (Ag and Ab reactive) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Invalid/Indeterminate		<b>Collection Date:</b> ___/___/_____ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT*: HIV-1 Ag</b>		<b>HIV-Ab</b>	
<input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not Reported		<input type="checkbox"/> HIV-1 Reactive <input type="checkbox"/> HIV-2 Reactive <input type="checkbox"/> Both Reactive, Undifferentiated <input type="checkbox"/> Both Nonreactive	
<b>Collection Date:</b> ___/___/_____		*Select one result for HIV-1 Ag and one result for HIV Ab	
<b>HIV Detection Tests (Qualitative)</b>			
<b>TEST:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/_____	
<b>HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis</b>			
<b>TEST 1:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
<b>RESULT:</b> <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		<b>Copies/mL:</b> _____	<b>Log:</b> _____ <b>Collection Date:</b> ___/___/_____
<b>TEST 2:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
<b>RESULT:</b> <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		<b>Copies/mL:</b> _____	<b>Log:</b> _____ <b>Collection Date:</b> ___/___/_____
<b>Immunologic Tests (CD4 count and percentage)</b>			
<b>CD4 at or closest to diagnosis: CD4 count:</b> _____ cells/μL <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/_____			
<b>First CD4 result &lt;200 cells/μL or &lt;14%: CD4 count:</b> _____ cells/μL <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/_____			
<b>Other CD4 result: CD4 count:</b> _____ cells/μL <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/_____			
<b>Documentation of Tests</b>			
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 specimen collection date of earliest positive test for this algorithm: ___/___/_____			
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]			
If laboratory tests were not documented,		<b>HIV-Infected</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date of diagnosis:</b> ___/___/_____
is patient confirmed by a physician as:		<b>Not HIV-Infected</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date of diagnosis:</b> ___/___/_____

**Clinical (record all dates as mm/dd/yyyy)**

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary*	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary*	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

\*If TB selected above, indicate RVCT Case Number:

**Birth History (for Perinatal Cases only)**

<b>Residence at Birth</b>			
Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Check if SAME as Current Address	
* Street Address		City	
County	State/Country	*ZIP Code	
<b>Facility of Birth</b>			
<input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone (    ) _____	*ZIP Code
Facility Type	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____
*Street Address	City	County	State/Country
<b>Birth History</b>			
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 antiretrovirals (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"/> 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:		
<b>Maternal Information</b>			
Maternal DOB	Maternal Last Name Soundex	Maternal Stateno	Maternal Country of Birth
*Other Maternal ID – List Type		Number	

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

<b>This child received or is receiving:</b>			
Neonatal ARVs for HIV prevention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date began: ___/___/_____	Date of last use: ___/___/_____	
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 began: ___/___/_____	Date of last use: ___/___/_____	
PCP Prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date began: ___/___/_____	Date of last use: ___/___/_____	
Was this child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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			

**Comments**


**\*Local/Optional Fields**


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. Information in CDC's National HIV 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).