

**National HIV Surveillance System (NHSS)**

Attachment 3(b)

Pediatric HIV Confidential Case Report Form

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

*First Name		*Middle Name		*Last Name		Last Name Soundex	
Alternate Name Type (example: 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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				*Current Address, Street			Address Date ____/____/____
*Phone (____)		City		County		State/Country	
*Medical Record Number				*Other ID Type		*Number	

U.S. Department of Health  
and Human Services**Pediatric HIV Confidential Case Report Form**  
(Patients aged <13 years at time of perinatal exposure or patients aged <13 years at time of  
diagnosis) \*Information NOT transmitted to CDCCenters for Disease Control  
and Prevention (CDC)

Form approved OMB no. 0920-0573 Exp. 02/28/2026

**II. Health Department Use Only (record all dates as mm/dd/yyyy)**

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			

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

Facility Name				*Phone (____)	
*Street Address					
City		County		State/Country	
*ZIP Code					
Facility Type <u>Inpatient:</u> <input type="checkbox"/> Hospital <u>Outpatient:</u> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <u>Other Facility:</u> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____					
Date Form Completed ____/____/____		*Person Completing Form		*Phone (____)	

**IV. 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 (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 ____/____/____	
Gender Identity <input type="checkbox"/> Boy <input type="checkbox"/> Girl <input type="checkbox"/> Transgender boy <input type="checkbox"/> Transgender girl <input type="checkbox"/> Additional gender identity (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown					
Date Identified ____/____/____					
Sexual Orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Additional sexual orientation (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown					
Date Identified ____/____/____					
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown				Expanded Ethnicity	
Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American (check all that apply) <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown				Expanded Race	

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

Address Event Type <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (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 current address					
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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary					
*Street Address					
City		County		State/Country	
*ZIP Code					

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, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

This report to 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, 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).

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

Diagnosis Type (check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Perinatal exposure <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 <u>Inpatient</u> : <input type="checkbox"/> Hospital <u>Outpatient</u> : <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <u>Other Facility</u> : <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____			
*Provider Name		*Provider Phone (     )	Specialty

**VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)**

Birthing person'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 birthing person's first positive test result to confirm infection ____/____/____	Child breastfed/chestfed by birthing person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes) Start Date ____/____/____ Stop Date ____/____/____ Child received premasticated/pre-chewed food from birthing person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
After 1977 and before the earliest known diagnosis of HIV infection, the birthing person had:	
Perinatally acquired HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Birthing person had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	<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
Birthing person had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received ____/____/____ Last date received ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 nonprescription 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 ____/____/____	<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) First date received ____/____/____ Last date received ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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
Been breastfed/chestfed by non-birthing person	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received premasticated/pre-chewed food from non-birthing person	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other documented risk (include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**VIII. Clinical: Opportunistic Illnesses (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 <sup>1</sup>	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary <sup>1</sup>	
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		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	

<sup>1</sup>If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

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

<b>HIV Immunoassays</b>			
<b>TEST</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-2 IA			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result Overall: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-1/2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <sup>3</sup> Overall interpretation: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index Value _____		Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level Index Value _____			
HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____			
HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <sup>4</sup> Overall interpretation: <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-1 positive with HIV-2 cross-reactivity <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity			
<input type="checkbox"/> HIV negative <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive			
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Collection Date ____/____/____			
HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 WB			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>HIV Detection Tests</b>			
<b>TEST</b> <input type="checkbox"/> HIV-1/2 RNA NAAT (Qualitative)		Lab Name _____	
Test Brand Name/Manufacturer _____		Provider Name _____	
Facility Name _____		Collection Date ____/____/____	
Result <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (HIV-1 and HIV-2) <input type="checkbox"/> HIV, not differentiated (HIV-1 or HIV-2) <input type="checkbox"/> Neither (negative)			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1 RNA NAAT (Qualitative and Quantitative)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result Qualitative: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		Collection Date ____/____/____	
Analyte results: HIV-1 Quantitative: <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit			
Copies/mL _____ Log _____			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>TEST</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative)			
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	
Result <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit <input type="checkbox"/> Not detected Copies/mL _____ Log _____			
Collection Date ____/____/____			
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider <sup>2</sup> <input type="checkbox"/> Lab test, self-collected sample			
<b>Drug Resistance Tests (Genotypic)</b>			
<b>TEST</b> <input type="checkbox"/> HIV-1 Genotype (Unspecified)		Test Brand Name/Manufacturer _____	
Lab Name _____		Facility Name _____	
Provider Name _____		Collection Date ____/____/____	
<b>Immunologic Tests (CD4 count and percentage)</b>			
CD4 count _____ cells/ $\mu$ L		CD4 percentage _____ %	
Collection Date ____/____/____		Collection Date ____/____/____	
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	

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

<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 result for this algorithm ____/____/____ <i>Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.</i>	
Is earliest evidence of diagnosis documented by a physician rather than by laboratory test results?	HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Not HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date of diagnosis by physician	____/____/____
Date of diagnosis by physician	____/____/____

<sup>2</sup>Results not directly observed by a provider should be recorded in HIV Testing History.<sup>3</sup>Complete the overall interpretation and the analyte results.<sup>4</sup>Always complete the overall interpretation. Complete the analyte results when available.**X. Birth History (for patients exposed perinatally with or without consequent infection)**

Birth history available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Residence at Birth <input type="checkbox"/> Check if SAME as current address					
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"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary					
*Street Address	City				
County	State/Country	*ZIP Code			
Facility of Birth <input type="checkbox"/> Check if SAME as facility providing information					
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone ( )			
Facility Type <u>Inpatient:</u> <input type="checkbox"/> Hospital <u>Outpatient:</u> <input type="checkbox"/> Other, specify _____ <u>Other Facility:</u> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____					
*Street Address		City			
County	State/Country	*ZIP Code			
Birth History	Birth Weight ____lbs ____oz ____grams	Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3-More than two <input type="checkbox"/> 9-Unknown			
Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown					
If Cesarean delivery, mark all the following indications that apply.					
<input type="checkbox"/> HIV indication (high viral load) <input type="checkbox"/> Previous Cesarean (repeat) <input type="checkbox"/> Malpresentation (breech, transverse)					
<input type="checkbox"/> Prolonged labor or failure to progress <input type="checkbox"/> Birthing person's or physician's preference <input type="checkbox"/> Fetal distress					
<input type="checkbox"/> Placenta abruptia or p. previa <input type="checkbox"/> Other (e.g., herpes, disproportion) (Specify) _____					
<input type="checkbox"/> Not specified					
Birth Information	Date	Time (use military time: noon = 12:00; midnight = 00:00)			
Rupture of membranes	____/____/____	____:____			
Delivery	____/____/____	____:____			
Congenital Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, specify types					
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> 9-Unknown		Neonatal Gestational Age in Weeks ____ (99 = Unknown, 00 = None)			
Was a toxicology screen done on the infant after birth?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If screening for the same substance was done on more than one occasion, record additional dates and results in Comments)	Result				
	Not screened	Date of screen	Positive	Negative	Unknown
	Alcohol	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Amphetamines	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Barbiturates	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Benzodiazepines	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cocaine	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crack cocaine	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fentanyl	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hallucinogens	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heroin	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	K2	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Marijuana (cannabis, THC, cannabinoids)	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Methadone	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Methamphetamines	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nicotine (any tobacco)	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Opiates	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PCP	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specific drug(s) not documented	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**XI. Birthing Person History (for patients exposed perinatally with or without consequent infection)**

Birthing Person Date of Birth ____ / ____ / ____		Birthing Person Last Name Soundex			
Birthing Person Country of Birth		Birthing Person State ID Number			
Birthing Person City/County ID Number		*Other Birthing Person ID (specify type of ID and ID number)			
Prenatal Care—Month of Pregnancy Prenatal Care Began (99 = Unknown, 00 = None)		Prenatal Care—Total Number of Prenatal Care Visits (99 = Unknown, 00 = None)			
Has the birthing person ever been pregnant before this pregnancy? Include previous pregnancies that ended in a live birth, miscarriage, stillbirth, or induced abortion.  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If YES, specify how many previous pregnancies _____				
		Pregnancy outcome (select one)		Year outcome occurred (9999 = Unknown)	
		Live birth	Miscarriage or Stillbirth	Induced abortion	
	i.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	ii.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
iii.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
iv.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
v.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(Record additional pregnancy outcomes in Comments)					
Was a test result (with a specimen collection date within the 6 weeks on or before delivery) documented in the birthing person's labor/delivery record CD4 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown      Quantitative NAAT (RNA or DNA) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Did birthing person receive any antiretrovirals (ARVs) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown					
Date began ____ / ____ / ____      Date of last use ____ / ____ / ____					
If YES, specify all ARVs _____					
Did birthing person receive any ARVs during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown					
Date began ____ / ____ / ____      Date of last use ____ / ____ / ____					
If YES, specify all ARVs _____					
If NO, select reason <input type="checkbox"/> No prenatal care <input type="checkbox"/> Birthing person known to be HIV-negative during pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> HIV serostatus of birthing person unknown <input type="checkbox"/> Other (specify) _____					
Did birthing person receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown					
Date began ____ / ____ / ____      Date of last use ____ / ____ / ____					
If YES, specify all ARVs _____					
If NO, select reason <input type="checkbox"/> Precipitous delivery/STAT Cesarean delivery <input type="checkbox"/> HIV serostatus of birthing person unknown <input type="checkbox"/> Birth not in hospital <input type="checkbox"/> Birthing person tested HIV negative during pregnancy <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					
Was the birthing person screened for any of the following conditions during this pregnancy?					
Check test(s) performed before birth					
	Yes	Date of screen (mm/dd/yyyy)	No	Unknown	
Group B strep	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (HBsAg)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Were any of the following conditions diagnosed for the birthing person during this pregnancy or at the time of labor and delivery?					
	Yes	Date of diagnosis (mm/dd/yyyy)	No	Unknown	
Bacterial vaginosis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Chlamydia trachomatis infection	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Genital herpes	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Gonorrhea	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Group B strep	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (HBsAg)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis C	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
PID	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Trichomoniasis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
Were substances used by the birthing person during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	Used and injected	Used and did not inject	Used and unknown if injected	Did not use	Unknown if used
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (cannabis, THC, cannabinoids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (any tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific drug(s) not documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**XI. Birthing Person History (for patients exposed perinatally with or without consequent infection) (cont)**

Was a toxicology screen done on the birthing person (either during this pregnancy or at the time of delivery)?

☐ Yes

☐ No

☐ Unknown

(If screening for the same substance was done on more than one occasion, record additional dates and results in Comments)

	Not screened	Date of screen	Positive	Negative	Unknown
Alcohol	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (cannabis, THC, cannabinoids)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (any tobacco)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)_____	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific drug(s) not documented	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Has this child ever taken any ARVs?

☐ Yes

☐ No

☐ Unknown

ARV medication	Reason for use						Date began	Date of last use
	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	Other (specify reason)		
i. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
ii. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
iii. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
iv. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
v. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___

(Record additional ARV medications in Comments)

Has this child ever taken PCP prophylaxis

☐ Yes

☐ No

☐ Unknown

Date began \_\_\_/\_\_\_/\_\_\_

Date of last use \_\_\_/\_\_\_/\_\_\_

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 (specify in comments)

☐ 9—Unknown

**XIII. Comments**

**XIV. \*Local/Optional Fields**