

**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 CDC

Centers for Disease Control  
and Prevention (CDC)**II. Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. NNNN-NNNN Exp. 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 <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 ( )

**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 (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	

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

Address Event Type (check all that apply to address below)	<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 <b>SAME</b> 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)**

<b>Diagnosis Type</b> (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			
<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>

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

<b>Birth person's HIV infection status</b> (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	
<b>Date of birthing person's first positive test result to confirm infection</b> ___/___/____	<b>Child breastfed/chestfed by birthing person</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Child received premasticated/pre-chewed food from birthing person</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>After 1977 and before the earliest known diagnosis of HIV infection, the birthing person had:</b>	
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
<b>Birthing person had HETEROSEXUAL relations with any of the following:</b>	
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
<b>Birthing person had:</b>	
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 nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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
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>		
TEST <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		
TEST <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		
TEST <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		
TEST <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	Collection Date ____/____/____	
<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 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		
TEST <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>		
TEST <input type="checkbox"/> HIV-1/2 RNA NAAT (Qualitative)		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
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)	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		
TEST <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		
TEST <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		
TEST <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>		
TEST <input type="checkbox"/> HIV-1 Genotype (Unspecified)		
Lab Name _____	Test Brand Name/Manufacturer _____	
Provider Name _____	Facility Name _____	
Collection Date ____/____/____		
<b>Immunologic Tests (CD4 count and percentage)</b>		
CD4 count _____ cells/ $\mu$ L	CD4 percentage _____ %	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)**

**Documentation of Tests**

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

If YES, provide specimen collection date of earliest positive test result for this algorithm \_\_\_\_/\_\_\_\_/\_\_\_\_  
 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.

Is earliest evidence of diagnosis documented by a physician rather than by laboratory test results? **HIV-infected**  Yes  No  Unknown **Date of diagnosis by physician** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Not HIV-infected**  Yes  No  Unknown **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?  Yes  No  Unknown

Residence at Birth  Check if SAME as current address

Address Type  Residential  Bad address  Correctional facility  Foster home  Homeless  Military  Other  Postal  Shelter  Temporary

\*Street Address \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State/Country \_\_\_\_\_ \*ZIP Code \_\_\_\_\_

Facility of Birth  Check if SAME as facility providing information

Facility Name of Birth \_\_\_\_\_ \*Phone (\_\_\_\_) \_\_\_\_\_  
 (if child was born at home, enter "home birth")

Facility Type **Inpatient:**  Hospital  Other, specify \_\_\_\_\_ **Outpatient:**  Other, specify \_\_\_\_\_ **Other Facility:**  Emergency room  Corrections  Unknown  Other, specify \_\_\_\_\_

\*Street Address \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State/Country \_\_\_\_\_ \*ZIP Code \_\_\_\_\_

Birth History \_\_\_\_\_ Birth Weight \_\_\_\_ lbs \_\_\_\_ oz \_\_\_\_ grams Type  1-Single  2-Twin  3-More than two  9-Unknown

Delivery  Vaginal  Cesarean  Unknown

If Cesarean delivery, mark all the following indications that apply.

HIV indication (high viral load)  Previous Cesarean (repeat)  Malpresentation (breech, transverse)  
 Prolonged labor or failure to progress  Birthing person's or physician's preference  Fetal distress  
 Placenta abruptia or p. previa  Other (e.g., herpes, disproportion) (Specify) \_\_\_\_\_  
 Not specified

Birth Information \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time (use military time: noon = 12:00; midnight = 00:00) \_\_\_\_:\_\_\_\_

Rupture of membranes \_\_\_\_/\_\_\_\_/\_\_\_\_ Delivery \_\_\_\_/\_\_\_\_/\_\_\_\_

Congenital Disorders  Yes  No  Unknown If YES, specify types \_\_\_\_\_

Neonatal Status  1-Full-term  2-Premature  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"/>	<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"/>

**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)																																																																																																																		
<p><b>Has the birthing person ever been pregnant before this pregnancy? Include previous pregnancies that ended in a live birth, miscarriage, stillbirth, or induced abortion.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																																																																																																			
<p style="text-align: center;"><b>If YES, specify how many previous pregnancies</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;"></th> <th style="width:15%;">Live birth</th> <th style="width:25%;">Miscarriage or Stillbirth</th> <th style="width:20%;">Pregnancy outcome (select one) Induced abortion</th> <th style="width:10%;">Year outcome occurred (9999 = Unknown)</th> </tr> </thead> <tbody> <tr> <td>i.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td>ii.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td>iii.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td>iv.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td>v.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> </tbody> </table> <p style="text-align: center;">(Record additional pregnancy outcomes in Comments)</p>			Live birth	Miscarriage or Stillbirth	Pregnancy outcome (select one) Induced abortion	Year outcome occurred (9999 = Unknown)	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"/>	_____																																																																																				
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<p><b>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</b></p> <p>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</p>																																																																																																																			
<p><b>Did birthing person receive any antiretrovirals (ARVs) prior to this pregnancy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown</p> <p>Date began ___/___/_____      Date of last use ___/___/_____</p> <p><b>If YES, specify all ARVs</b> _____</p>																																																																																																																			
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<p><b>Did birthing person receive any ARVs during labor/delivery?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown</p> <p>Date began ___/___/_____      Date of last use ___/___/_____</p> <p><b>If YES, specify all ARVs</b> _____</p> <p><b>If NO, select reason</b> <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</p>																																																																																																																			
<p><b>Was the birthing person screened for any of the following conditions during this pregnancy?</b></p> <p style="text-align: center;"><b>Check test(s) performed before birth</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;"></th> <th style="width:10%;">Yes</th> <th style="width:30%;">Date of screen (mm/dd/yyyy)</th> <th style="width:10%;">No</th> <th style="width:10%;">Unknown</th> </tr> </thead> <tbody> <tr> <td>Group B strep</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis B (HBsAg)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Rubella</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Syphilis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			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"/>																																																																																									
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<p><b>Were any of the following conditions diagnosed for the birthing person during this pregnancy or at the time of labor and delivery?</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;"></th> <th style="width:10%;">Yes</th> <th style="width:30%;">Date of diagnosis (mm/dd/yyyy)</th> <th style="width:10%;">No</th> <th style="width:10%;">Unknown</th> </tr> </thead> <tbody> <tr> <td>Bacterial vaginosis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><i>Chlamydia trachomatis</i> infection</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Genital herpes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Gonorrhea</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Group B strep</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis B (HBsAg)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis C</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>PID</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Syphilis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Trichomoniasis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">___/___/_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			Yes	Date of diagnosis (mm/dd/yyyy)	No	Unknown	Bacterial vaginosis	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	<i>Chlamydia trachomatis</i> 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"/>																																																											
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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"/>
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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)? <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)					
	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**
