

Patient Identification

*Patient Name	*First Name	*Middle Name	*Last Name	Last Name Soundex
*Alternate Name Type (ex Birth, Call Me)		*First Name	*Middle Name	*Last Name
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary		*Current Street Address		*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**

Form approved OMB no 0920-0573 Exp. 02/29/2016

Date Received at Health Department ___/___/___	eHARS Document UID _____	State Number _____
Reporting Health Dept - City / County		City/County Number
Document Source _____	Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Report Medium <input type="checkbox"/> 1-Field Visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic Transfer <input type="checkbox"/> 6-CD/Disk	

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

Facility Name			*Phone () _____
*Street Address			
City	County	State/Country	ZIP Code
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
Date Form Completed ___/___/___	*Person Completing Form	*Phone () _____	

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

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

Residence at Diagnosis (add additional addresses in Comments)

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

Physician's Name: (Last, First, M.I.)

Medical Record

Phone No: () _____

No. _____

Hospital/Facility:

Person Completing Form:

Facility of Diagnosis (add additional facilities in Comments)Diagnosis Type HIV AIDS Perinatal Exposure (check all that apply to facility below) Check if SAME as Facility Providing Information

Facility Name

*Phone () _____

*Street Address

City

County

State/Country

ZIP Code

Facility Type *Inpatient:* Hospital
 Other, specify _____*Outpatient:* Private Physician's Office Pediatric Clinic
 Pediatric HIV Clinic Other, specify _____*Other Facility:* Emergency Room Laboratory
 Unknown Other, specify _____

*Provider Name

*Provider Phone () _____

*Specialty

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)Child's biological mother's HIV infection status (select one): 1-Refused HIV testing 2-Known to be uninfected after this child's birth 3-Known HIV+ before pregnancy 4-Known HIV+ during pregnancy 5-Known HIV+ sometime before birth 6-Known HIV+ at delivery 7-Known HIV+ after child's birth 8-HIV+, time of diagnosis unknown 9-HIV status unknown

Date of mother's first positive HIV confirmatory test: ___/___/_____

Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? Yes No Unknown**After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:**

Perinatally acquired HIV infection

 Yes No Unknown

Injected non-prescription drugs

 Yes No Unknown**Biological Mother had HETEROSEXUAL relations with any of the following:**

HETEROSEXUAL contact with intravenous/injection drug user

 Yes No Unknown

HETEROSEXUAL contact with bisexual male

 Yes No Unknown

HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with transfusion recipient with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with transplant recipient with documented HIV infection

 Yes No Unknown

HETEROSEXUAL contact with person with documented HIV infection, risk not specified

 Yes No Unknown

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)

 Yes No Unknown

First date received ___/___/_____ Last date received ___/___/_____

Received transplant of tissue/organs or artificial insemination

 Yes No Unknown**Before the diagnosis of HIV infection, this child had:**

Injected non-prescription drugs

 Yes No UnknownReceived clotting factor for hemophilia/
coagulation disorderSpecify clotting factor:
Date received: ___/___/_____ Yes No Unknown

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)

 Yes No Unknown

First date received ___/___/_____ Last date received ___/___/_____

Received transplant of tissue/organs

 Yes No Unknown

Sexual contact with male

 Yes No Unknown

Sexual contact with female

 Yes No Unknown

Other Documented Risk (please include detail in Comments section)

 Yes No Unknown

Laboratory Data (record additional tests in Comments section) (record all dates as mm/dd/yyyy)

HIV Antibody Tests (Non-type-differentiating) [HIV-1 vs. HIV-2]

TEST 1: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

RESULT: Positive/Reactive Negative/Nonreactive Indeterminate **RAPID TEST** (check if rapid): **Collection Date:** ___/___/_____

Manufacturer: _____

TEST 2: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

RESULT: Positive/Reactive Negative/Nonreactive Indeterminate **RAPID TEST** (check if rapid): **Collection Date:** ___/___/_____

Manufacturer: _____

TEST 3: HIV-1 IA HIV-1/2 IA HIV-1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 IA HIV-2 WB Other: Specify Test: _____

RESULT: Positive/Reactive Negative/Nonreactive Indeterminate **RAPID TEST** (check if rapid): **Collection Date:** ___/___/_____

Manufacturer: _____

HIV Antibody Tests (Type-differentiating) [HIV-1 vs. HIV-2]

TEST: HIV-1/2 Differentiating (e.g., Multispot)

RESULT: HIV-1 HIV-2 Both (undifferentiated) Neither (negative) Indeterminate **Collection Date:** ___/___/_____

HIV Detection Tests (Qualitative)

TEST 1: HIV-1 RNA/DNA NAAT (Qual) HIV-1 P24 Antigen HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture

RESULT: Positive/Reactive Negative/Nonreactive Indeterminate **Collection Date:** ___/___/_____

TEST 2: HIV-1 RNA/DNA NAAT (Qual) HIV-1 P24 Antigen HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture

RESULT: Positive/Reactive Negative/Nonreactive Indeterminate **Collection Date:** ___/___/_____

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

TEST 1: HIV-1 RNA/DNA NAAT (Quantitative viral load)

RESULT: Detectable Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** ___/___/_____

TEST 2: HIV-1 RNA/DNA NAAT (Quantitative viral load)

RESULT: Detectable Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** ___/___/_____

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to current diagnostic status: CD4 count: _____ cells/μL **CD4 percentage:** ____% **Collection Date:** ___/___/_____

First CD4 result <200 cells/μL or <14%: CD4 count: _____ cells/μL **CD4 percentage:** ____% **Collection Date:** ___/___/_____

Other CD4 result: CD4 count: _____ cells/μL **CD4 percentage:** ____% **Collection Date:** ___/___/_____

Documentation of Tests

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

If YES, provide date of earliest positive test for this algorithm (specimen collection date if known): ___/___/_____

Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]:

If laboratory tests were not documented, **HIV-Infected** Yes No Unknown **Date of diagnosis:** ___/___/_____

is patient confirmed by a physician as: **Not HIV-Infected** Yes No Unknown **Date of diagnosis:** ___/___/_____

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

Diagnosis	OIs	Date	Diagnosis	OIs	Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)			Kaposi's sarcoma		
Candidiasis, bronchi, trachea, or lungs			Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia		
Candidiasis, esophageal			Lymphoma, Burkitt's (or equivalent)		
Coccidioidomycosis, disseminated or extrapulmonary			Lymphoma, immunoblastic (or equivalent)		
Cryptococcosis, extrapulmonary			Lymphoma, primary in brain		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)			Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		
Cytomegalovirus disease (other than in liver, spleen, or nodes)			M. tuberculosis, disseminated or extrapulmonary [†]		
Cytomegalovirus retinitis (with loss of vision)			Mycobacterium, of other/unidentified species, disseminated or extrapulmonary		
HIV encephalopathy			Pneumocystis pneumonia		
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis			Progressive multifocal leukoencephalopathy		
Histoplasmosis, disseminated or extrapulmonary			Toxoplasmosis of brain, onset at >1 mo. of age		
Isosporiasis, chronic intestinal (>1 mo. duration)			Wasting syndrome due to HIV		
Has this child been diagnosed with pulmonary tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, initial diagnosis: <input type="checkbox"/> Definitive <input type="checkbox"/> Presumptive <input type="checkbox"/> Unknown		Date:	†If TB selected above, indicate RVCT Case Number:	

Birth History (for Perinatal Cases only)

Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Residence at Birth <input type="checkbox"/> Check if <u>SAME</u> as Current Address	
* Street Address		City	
County	State/Country	*ZIP Code	
Hospital of Birth			
<input type="checkbox"/> Check if <u>SAME</u> as Facility Providing Information			
Facility Name		*Phone () _____	ZIP Code
*Street Address	City	County	State/Country
Birth History			
Birth Weight _____ lbs _____ oz _____ grams	Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3->2 <input type="checkbox"/> 9-Unknown	Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Non-Elective Cesarean <input type="checkbox"/> 4-Cesarean, unknown type <input type="checkbox"/> 9-Unknown	
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please specify:		
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> Unknown	Neonatal Gestational Age in Weeks: _____ (99-Unknown)		
Gestational Month Prenatal Care Began (00-None, 99-Unknown)	Prenatal Care – Total number of prenatal care visits: (00-None, 99-Unknown)		
Did mother receive any Anti-retrovirals (ARVs) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown	If yes, please specify all:		
Did mother receive any ARVs during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please specify all:		
Did mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please specify all:		
Maternal Information			
Maternal DOB	Maternal Soundex	Maternal Stateno	Maternal Country of Birth
*Other Maternal ID – List Type:		Number:	

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

This child received or is receiving:	
Neonatal ARVs for HIV prevention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: ____/____/____
If Yes, please specify: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____	
Anti-retroviral therapy for HIV treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: ____/____/____
PCP Prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date: ____/____/____	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).