

**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 CDC

Centers for Disease Control  
and Prevention**Health Department Use Only**

Form approved OMB no 0920-0573 Exp. 01/31/2013

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 SAME as Current Address
* Street Address					
City	County	State/Country	*ZIP Code		

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/AIDS. Information in CDC's HIV/AIDS 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).

## STATE/LOCAL USE ONLY

- Patient identifier information is not transmitted to CDC! -

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

Medical Record

Phone No: ( ) \_\_\_\_\_

No. \_\_\_\_\_

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

Person Completing Form: \_\_\_\_\_

Phone No: ( ) \_\_\_\_\_

**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  UnknownInjected 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  UnknownHETEROSEXUAL contact with bisexual male  Yes  No  UnknownHETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with transfusion recipient with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with transplant recipient with documented HIV infection  Yes  No  UnknownHETEROSEXUAL contact with person with AIDS or documented HIV Infection, risk not specified  Yes  No  UnknownReceived transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)  
First date received \_\_\_\_/\_\_\_\_/\_\_\_\_ Last date received \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  UnknownReceived 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 disorder Specify clotting factor:  
Date received (mm/ dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  UnknownReceived transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)  
First date received \_\_\_\_/\_\_\_\_/\_\_\_\_ Last date received \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  UnknownReceived transplant of tissue/organs  Yes  No  UnknownSexual contact with male  Yes  No  UnknownSexual contact with female  Yes  No  UnknownOther Documented Risk (please include detail in Comments section)  Yes  No  Unknown

**Laboratory Data (record additional tests in Comments section)**

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

**TEST 1:**  HIV-1 EIA  HIV-1/2 EIA  HIV-1/2 Ag/Ab  HIV-1 WB  HIV-1 IFA  HIV-2 EIA  HIV-2 WB  Other: Specify Test: \_\_\_\_\_

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

**TEST 2:**  HIV-1 EIA  HIV-1/2 EIA  HIV-1/2 Ag/Ab  HIV-1 WB  HIV-1 IFA  HIV-2 EIA  HIV-2 WB  Other: Specify Test: \_\_\_\_\_

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

**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) **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 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/ $\mu$ L **CD4 percentage:** \_\_\_\_\_% **Collection Date:** \_\_\_/\_\_\_/\_\_\_

**First CD4 result <200 cells/ $\mu$ L or <14%: CD4 count:** \_\_\_\_\_ cells/ $\mu$ L **CD4 percentage:** \_\_\_\_\_% **Collection Date:** \_\_\_/\_\_\_/\_\_\_

**Documentation of Tests**

**If laboratory tests were not documented,** **HIV-Infected**  Yes  No  Unknown **Date of Documentation:** \_\_\_/\_\_\_/\_\_\_

**is patient confirmed by a physician as:** **Not HIV-Infected**  Yes  No  Unknown **Date of Documentation:** \_\_\_/\_\_\_/\_\_\_

**Clinical (select D for Definitive or P for Presumptive where applicable) (record all dates as mm/dd/yyyy)**

	D	P	Date		D	P	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 <sup>†</sup>			
Cytomegalovirus retinitis (with loss of vision)				Mycobacterium, of other/identified 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:	<sup>†</sup> If TB selected above, indicate RVCT Case Number:		

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.**

**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 SAME as Current Address	
* Street Address		City	
County	State/Country	*Zip Code	
<b>Hospital of Birth</b>			
<input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name		*Phone ( ) _____	Zip Code
*Street Address		City	County State/Country
<b>Birth History</b>			
Birth Weight _____ lbs _____ oz _____ grams		Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3->2 <input type="checkbox"/> 9-Unknown	Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Non-Elective Cesarean <input type="checkbox"/> 4-Cesarean, unknown type <input type="checkbox"/> 9-Unknown
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, please specify:	
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> Unknown		Neonatal Status Weeks: _____ (99-Unknown)	
Prenatal Care – Month of Pregnancy Prenatal Care began _____ (00-None, 99-Unknown)		Prenatal Care - Total number of prenatal care visits: _____ (00-None, 99-Unknown)	
Did mother receive zidovudine (ZDV,AZT) during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, what week of pregnancy was zidovudine (ZDV, AZT) started: _____ (99-Unknown)	
Did mother receive zidovudine (ZDV,AZT) during labor/delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		Did mother receive zidovudine (ZDV,AZT) prior to this pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Did mother receive any other Anti-retroviral medication during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, please specify:	
Did mother receive any other Anti-retroviral medication during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, please specify:	
<b>Maternal Information</b>			
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 zidovudine (ZDV,AZT) for HIV prevention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: ____/____/____
Other neonatal anti-retroviral medication 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**
