Pediatric HIV/AIDS Confidential Case Report

(Patients < 13 years of age at time of diagnosis)

I. HEALTH DEPT USE ONLY

Document Source	New Investigation	Report Medium	Surveillance Method	State Number
A0_____	Y N U	FV M Ph ET	A F P R U	
Reporting Site/City: LAC(CA01)		**Report Status:** New Update		**City Number**
Date form completed: / /	**Person completing form:**			

II. PATIENT IDENTIFIER INFORMATION- *data not transmitted to CDC*

Name: (Last,First,M.I.)	**Last Evaluation for HIV** (mm/yyyy):_____/_____
LN Sndx: Alias: SS#: - -	**Initial Evaluation for HIV** (mm/yyyy):_____/_____
Current Address: City/County	
State: Zip: Phone: ( )	

III. DEMOGRAPHIC INFORMATION

Diagnostic Status	Sex	Date of Birth	Status	Date of Death	Country of Birth
☐ Perinatally Exposed ☐ Confirmed HIV Infection ☐ AIDS ☐ Seroreverter	☐ Male ☐ Female	__/__/____	☐ Alive ☐ Dead ☐ Unk.	__ __/__ __/__ __ __ __ State/Terr of Death: _____	☐ U.S. ☐ U.S. Depend/Posses ☐ Unknown ☐ Other*_____ * If Other or U.S. Depend/Possess,specify:

Ethnicity (select one): ☐ Hispanic ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/Af.Am ☐ White ☐ Hawaiian/PI ☐ Unknown

For Hispanics and Asians, please specify extended race:_____

Residence at Diagnosis: ☐ Same as Current ☐ Homeless ☐ Outside of US. Specify (city/country):_____/_____

Exp: Address:_____ **N/A** City:_____ County:_____ State:_____ Zip:_____

HIV: Address:_____ City:_____ County:_____ State:_____ Zip:_____

AIDS: Address:_____ City:_____ County:_____ State:_____ Zip:_____

IV. FACILITY OF DIAGNOSIS

Facility Name:

Address:

City:

State/Country: Zip:

Facility Setting (check one):
☐ Public ☐ Federal
☐ Private ☐ Other

Facility Type (check one):
☐ Hosp Inpatient ☐ HIV Clinic
☐ Outpatient ☐ Other
☐ Private Physician

V. REPORTING PROVIDER INFORMATION

Provider Name:

Provider Ph. No. ( )

Med. Rec. No:

Facility:

City/State:

VI. PATIENT / MATERNAL HISTORY

Child's biological mother's HIV infection status:

☐ Refused HIV testing ☐ Known to be uninfected after this child's birth ☐ HIV status unknown
☐ Known HIV+ before pregnancy ☐ Known HIV+ at time of delivery ☐ Known HIV+ after the child's birth
☐ Known HIV+ during pregnancy ☐ Known HIV+ sometime before birth ☐ HIV+, time of diagnosis unknown

Date of mother's first positive HIV confirmatory test (mm/dd/yyyy): __ __/__ __/__ __ __ __

Mother was counseled about HIV testing during this pregnancy, labor or delivery? ☐ Yes ☐ No ☐ Unknown

Before the diagnosis of HIV/AIDS , this child's biological mother had:	**Yes**	**No**	**Unk**
Perinatally acquired HIV	☐	☐	☐
Injected non-prescription drugs	☐	☐	☐
HETEROSEXUAL relations with any of the following:			
Intravenous/injection drug user	☐	☐	☐
Bisexual male	☐	☐	☐
Male with hemophilia/coagulation disorder	☐	☐	☐
Transfusion recipient with documented HIV Infection	☐	☐	☐
Transplant recipient with documented HIV infection	☐	☐	☐
Male with AIDS or documented HIV infection, risk not specified	☐	☐	☐
Male with perinatally-acquired HIV	☐	☐	☐
Received transfusion of blood/blood components (other than clotting factor)	☐	☐	☐
Received transplant of tissue/organs or artificial insemination	☐	☐	☐

Before the diagnosis of HIV/AIDS, this child had:	**Yes**	**No**	**Unk**
Injected nonprescription drugs	☐	☐	☐
Received clotting factor for hemophilia/coagulation disorder ☐ Factor VIII ☐ Factor IX ☐ Other Date received mm/dd/yyyy: __ __/__ __/__ __ __ __	☐	☐	☐
Received transfusion of blood/blood components (other than clotting factor) First date received (mm/yy): __ __/__ __ Last date received (mm/yy): __ __/__ __	☐	☐	☐
Received transplant of tissue/organs	☐	☐	☐
Is transplant or artificial insemination being investigated as primay mode of exposure?	☐	☐	☐

Continued under SectionXI-pg.3 (COMMENTS)

VII. TREATMENT/SERVICES REFERRALS

This child received or is receiving:		**Date Started** (mm/dd/yyyy)
Neonatal zidovudine (ZDV, AZT) for HIV prevention	☐ Yes ☐ No ☐ Unknown	
Other neonatal anti-retroviral medication for HIV prevention	☐ Yes ☐ No ☐ Unknown	
If **Yes**, specify the medications & date received: _____, _____, _____		
Anti-retroviral therapy for HIV treatment	☐ Yes ☐ No ☐ Unknown	
PCP prophylaxis	☐ Yes ☐ No ☐ Unknown	
Was the child breastfed?	☐ Yes ☐ No ☐ Unknown	

This patient has been enrolled at **clinical trial** ☐ NIH sponsored ☐ Other ☐ None ☐ Unknown

This patient has been enrolled at **clinic** ☐ HRSA sponsored ☐ Other ☐ None ☐ Unknown

At the time of HIV/AIDS diagnosis, medical treatment is primarily reimbursed by: ☐ Medicaid ☐ Pvt. Ins/HMO ☐ No Coverage ☐ Other ☐Unk

This child's primary caretaker is: ☐ Biological parents ☐ Foster/adoptive parent, relative ☐ Social service agency ☐ Unknown ☐ Other relative ☐ Foster/adoptive parent, unrelated ☐ Other (please specify)

VIII. LABORATORY DATA

HIV Antibody Tests at Diagnosis: (Indicate **FIRST** test mm/dd/yyyy)

	Positive	Negative
HIV-1 EIA		
HIV-1 EIA		
HIV-1 / HIV-2 combin. EIA		
HIV-1 Western Blot / IFA		
HIV-1 Western Blot / IFA		
Other(specify):_____		

HIV Detection Tests: (Record **ALL** tests-mm/dd/yyyy)

	Positive	Negative
HIV-1 P24 Antigen		
HIV-1 RNA PCR (Qual)		
HIV-1 RNA PCR (Qual)		
HIV-1 Proviral DNA (Qual)		
HIV-1 Proviral DNA (Qual)		
Other(specify): _____		

HIV Viral Load Tests: (**most recent** test- mm/dd/yyyy)

Type Name	Copies / ML	Test Date
HIV-1 RNA NASBA		
HIV-1 RNA RT-PCR		
HIV-1 RNA bDNA		
HIV-1 RNA Other		

Immunologic Lab Test: (test date-mm/dd/yyyy)

At or closest to current diagnostic status	Test Date
CD4 Count:_____ cells/ul (_____%)	
First<200 or <14% of total lymphocytes	
CD4 Count:_____ cells/ul (_____%)	

IF HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ☐ Yes ☐ No ☐ Unknown

PHYSICIAN DIAGNOSIS:

If laboratory tests were not documented, is patient confirmed by a physician as:

HIV- infected ☐ Yes ☐ No ☐ Unknown If **Yes**, enter date of documentation (mm/dd/yyyy) ___/___/_____

Not HIV- infected ☐ Yes ☐ No ☐ Unknown If **Yes**, enter date of documentation (mm/dd/yyyy) ___/___/_____

IX. CLINICAL STATUS (Def. = Definitive diagnosis / Pres. = Presumptive diagnosis)

AIDS INDICATOR DISEASES	Initial Dx Date mm/dd/yy	Def.	Pres.	**AIDS INDICATOR DISEASES**	Initial DxDate mm/dd/yy	Def.	Pres.
Bacterial infection, multiple or recurrent (including Salmonella septicemia)	___/___/___	☐	NA	Kaposi's sarcoma	___/___/___	☐	☐
Candidiasis, bronchi, trachea, or lungs	___/___/___	☐	NA	Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	___/___/___	☐	☐
Candidiasis, esophageal	___/___/___	☐	☐	Lymphoma, Burkitt's (or equivalent)	___/___/___	☐	NA
Coccidioidomycosis, disseminated or extrapulmona	___/___/___	☐	NA	Lymphoma, immunoblastic (or equivalent)	___/___/___	☐	NA
Cryptococcosis, extrapulmonary	___/___/___	☐	NA	Lymphoma, primary in brain	___/___/___	☐	NA
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	___/___/___	☐	NA	Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	___/___/___	☐	☐
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at > 1 mo of age	___/___/___	☐	NA	M. tuberculosis, disseminated, or extrapulmonary *	___/___/___	☐	☐
Cytomegalovirus retinitis (with loss of vision)	___/___/___	☐	☐	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	___/___/___	☐	☐
HIV encephalopathy	___/___/___	☐	NA	Pneumocystis carinii pneumonia	___/___/___	☐	☐
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis onset>1 mo of age	___/___/___	☐	NA	Progressive multifocal leukoencephalopathy	___/___/___	☐	NA
Histoplasmosis, disseminated, or extrapulmonary	___/___/___	☐	NA	Toxoplasmosis of brain, onset at >1 mo of age	___/___/___	☐	☐
Isosporiasis, chronic intestinal (>1 mo. duration)	___/___/___	☐	NA	Wasting syndrome due to HIV	___/___/___	☐	NA

Has this child been diagnosed with pulmonary tuberculosis?* ☐Yes ☐ No ☐ Unk. *RVCT Case NO: _____

If **Yes,** initial diagnosis: ☐ TB pre- 1993 ☐ Definitive ☐ Presumptive ☐ Unknown Date of Diagnosis (mm/yyyy):_____

X. BIRTH HISTORY

Birth history available for this child: ☐ Yes ☐ No ☐ Unknown

Residence at Birth: ☐ Same Address as patient address Address: _____

City: _____ County: _____ State/Country: _____ Zip: _____

Hospital at Birth: Facility Name: _____ Phone No: ( ) _____

City: _____ County: _____ State/Country: _____ Zip: _____

BIRTHWEIGHT:

enter lbs/oz OR grams

_____**(lbs)** _____ **(oz)**

_____ **(g)**

Birth Type: ☐ Single ☐ Twin ☐ > 2 ☐ Unknown

Birth Delivery: ☐ Vaginal ☐ Elective Caesarean ☐ Non-elective Caesarean ☐ Caesarean, Unknown type ☐ Unknown

Birth Defects: ☐ Yes ☐ No ☐ Unknown If **Yes,** specify types and enter codes, if known:

Specify types(s): _____ **Code:** _____

Specify types(s): _____ **Code:** _____

NEONATAL STATUS: ☐ Full term ☐ Premature No. of weeks (gestational age) _____ (..-Unknown)

PRENATAL CARE:

Did Mom receive any **prenatal care** for this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Month of pregnancy prenatal care began: _____ (..-Unknown) (00=None)

Total number of prenatal care **visits:** _____ (..-Unknown) (00=None)

Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown

If **Yes**, week of pregnancy when zidovudine (ZDV, AZT) began: weeks _____ (..=Unknown)

Did mother receive zidovudine (ZDV, AZT) during labor/delivery? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Did mother receive any other antiretroviral meds during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown

If **Yes**, specify: _____

Did mother receive any other antiretroviral meds during labor/delivery? ☐ Yes ☐ No ☐ Refused ☐ Unknown

If **Yes**, specify: _____

BIOLOGICAL MOTHER'S BASIC DEMOGRAPHICS:

Biological Mother's Date of Birth (mm/dd/yyyy): __ __/ __ __/ __ __ __ __

Biological Mother's State Patient Number: _____

Biological Mother's Soundex: _____

Birthplace of Biological Mother:

☐ U.S. ☐ U.S. Dependencies and Possessions (including Puerto Rico)

☐ Unknown ☐ Other (specify): _____

XI. COMMENTS (if available, include any information on this child's biological siblings)

Continued from page 1….

Before the diagnosis of HIV/AIDS, this child had: (respond to **ALL** categories)	**Yes**	**No**	**Unk**
Sexual contact with a male	☐	☐	☐
Sexual contact with a female	☐	☐	☐
Is pediatric sexual contact being investigated or considered as primary mode of exposure?	☐	☐	
Other documented risk (Alert State/City NIR Coordinator)	☐	☐	☐

XI. COMMENTS (continued)

MAIL COMPLETED FORM TO:

LOS ANGELES COUNTY DEPT. OF PUBLIC HEALTH

ATTN: AZITA NAGHDI, MPH

600 S. COMMONWEALTH AVE., ~~SUITE 1260~~ 10F - SUITE 1260

LOS ANGELES, CA 90005

(213) 351-8153