

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

*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 Address, Street				Address Date ____/____/____	
*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 (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 06/30/2019

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 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/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown					Expanded Race _____		

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

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						Address Date ____/____/____	
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.**

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.) _____

*Phone () _____

Hospital/Facility _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (Check all that apply to facility below) HIV AIDS Perinatal Exposure Check if SAME as Facility Providing Information

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 _____	
*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): Refused HIV testing Known to be uninfected after this child's birth
 Known HIV+ before pregnancy Known HIV+ during pregnancy Known HIV+ sometime before birth Known HIV+ at delivery
 Known HIV+ after child's birth HIV+, time of diagnosis unknown 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<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
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 non-prescription 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
Other documented risk (please include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

HIV Immunoassays (Non-differentiating)			
TEST 1: <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-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB			
Test Brand Name/Manufacturer: _____			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		Collection Date: ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
TEST 2: <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-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB			
Test Brand Name/Manufacturer: _____			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		Collection Date: ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
HIV Immunoassays (Differentiating)			
<input type="checkbox"/> HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Indeterminate		Collection Date: ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)			
Test Brand Name/Manufacturer: _____			
RESULT: <input type="checkbox"/> Ag reactive <input type="checkbox"/> Ab reactive <input type="checkbox"/> Both (Ag and Ab reactive) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Invalid/Indeterminate		Collection Date: ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
RESULT*: HIV-1 Ag		HIV-Ab	
<input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not Reported		<input type="checkbox"/> HIV-1 Reactive <input type="checkbox"/> HIV-2 Reactive <input type="checkbox"/> Both Reactive, Undifferentiated <input type="checkbox"/> Both Nonreactive	
Collection Date: ___/___/___		*Select one result for HIV-1 Ag and one result for HIV Ab	
HIV Detection Tests (Qualitative)			
TEST: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture			
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		Collection Date: ___/___/___	
HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis			
TEST 1: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		Copies/mL: _____ Log: _____ Collection Date: ___/___/___	
TEST 2: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
RESULT: <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		Copies/mL: _____ Log: _____ Collection Date: ___/___/___	
Immunologic Tests (CD4 count and percentage)			
CD4 at or closest to diagnosis: CD4 count: _____ cells/ μ L CD4 percentage: ___% Collection Date: ___/___/___			
First CD4 result <200 cells/μL or <14%: CD4 count: _____ cells/ μ L CD4 percentage: ___% Collection Date: ___/___/___			
Other CD4 result: CD4 count: _____ cells/ μ L CD4 percentage: ___% Collection Date: ___/___/___			
Documentation of Tests			
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 for this algorithm: ___/___/___			
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]			
If laboratory tests were not documented,		HIV-Infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of diagnosis: ___/___/___	
is patient confirmed by a physician as:		Not HIV-Infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of diagnosis: ___/___/___	

Clinical (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*	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary*	
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 hyperplasia		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	

*If TB selected above, indicate RVCT Case Number:

Birth History (for Perinatal Cases only)

Residence at Birth			
Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Check if SAME as Current Address	
* 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 () _____	*ZIP Code
Facility Type	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____
*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 antiretrovirals (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 Last Name 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 began: ___/___/___ Date of last use: ___/___/___
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 began: ___/___/___ Date of last use: ___/___/___
PCP Prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date began: ___/___/___ Date of last use: ___/___/___
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).