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)			**HIV Detection Tests**: (Record **ALL** tests-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 P24 Antigen		
HIV-1 EIA			HIV-1 RNA PCR (Qual)		
HIV-1 / HIV-2 combin. EIA			HIV-1 RNA PCR (Qual)		
HIV-1 Western Blot / IFA			HIV-1 Proviral DNA (Qual)		
HIV-1 Western Blot / IFA			HIV-1 Proviral DNA (Qual)		
Other(specify):_____			Other(specify): _____		

HIV Viral Load Tests: (**most recent** test- mm/dd/yyyy)			**Immunologic Lab Test**: (test date-mm/dd/yyyy)	
Type Name	Copies / ML	Test Date	At or closest to current diagnostic status	Test Date
HIV-1 RNA NASBA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RNA RT-PCR			**First<200 or <14% of total lymphocytes**	
HIV-1 RNA bDNA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RNA Other				

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

LOS ANGELES, CA 90005

(213) 351-8153