Pediatric HIV/AIDS Confidential Case Report (for patients less than 13 years of age at time of diagnosis)

Return completed form to state/local health department

_______________ Date received at Health Department (enter all dates in mm/dd/yyyy format) **Providers: It is not necessary to fill in the grey areas.**

I. Patient Name (last name, first name, and middle initial) and Address

Patient's Name	Alias	Phone No.

Current Address	City	County	State	ZIP Code

_______________ Date form completed | Document source ________________________________ or source code: **A** ___ ___ . ___ ___ . ___ ___ . ___ ___

II. Health Department Use Only

Soundex Code	Did this report initiate a new case investigation? ☐ Yes ☐ No	Reporting Health Department / State	State Patient Number
Surveillance Method		City/County	City/County Patient Number
A · F · P · R · U	Report Medium: Field Visit · Mailed · Faxed · Phone · E. Transfer · Diskette		

Note: Record additional identifiers, such as Social Security number, in the Comments box (Section X). Record the number and type of ID.

III. Demographic Information

Diagnostic Status at Report	Date of Last Medical Evaluation (Month / Day / Year)	Date of Birth (Month / Day / Year)	Age at HIV Diagnosis (not AIDS) (Years / Months)
☐ Perinatal HIV Exposure ☐ Pediatric HIV ☐ Pediatric AIDS ☐ Presumptively uninfected ☐ Pediatric Seroreverter / Definitively uninfected	Date of Initial Evaluation for HIV (Month / Day / Year)	Alias Date of Birth (Month / Day / Year)	Age at AIDS Diagnosis (Years / Months)

Was reason for initial HIV evaluation due to clinical signs and symptoms: ☐ Yes ☐ No ☐ Unknown

Sex at Birth	Vital Status	Date of Death (Month / Day / Year)	State/Territory of Death
☐ Male ☐ Female ☐ Unknown	☐ Alive ☐ Dead ☐ Unknown		

Country of Birth: ☐ U.S. ☐ U.S. Minor Outlying Area ☐ Other ☐ Unknown

If **Other** or **U.S. Minor Outlying Area**, specify:

Ethnicity	Extended Ethnicity	Race (please select all that apply)		Extended Race
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian ☐ White ☐ Unknown	

Residence at Diagnosis ☐Same address as patient address (note: if patient was living at same address as above when **diagnosed** then check here)

Address	City	County	State/Country	ZIP Code

IV. Facility and Provider of Diagnosis / Perinatal Exposure / Facility of Care

☐ HIV diagnosis ☐ Perinatal exposure ☐ AIDS diagnosis ☐ Facility/Provider of care | Facility Name

Address	City	County	State/Country	ZIP Code

Facility Setting	Facility Type		HRSA Funding
☐ Public ☐ County ☐ Federal ☐ City ☐ State ☐ Private Specify setting, if **Federal**:	☐ Inpatient Facility ☐ Outpatient Facility ☐ Emergency Room ☐ Screening, Diagnostic, Referral Agency ☐ Laboratory ☐ Other ☐ Unknown	Specify type of facility:	☐ None ☐ Title IV ☐ Title I ☐ SPNS ☐ Title II ☐ Other ☐ Title III ☐ Unknown

Provider Name		Provider Specialty
Provider Phone No.	Medical Record No.	
Person Completing Form (PCF)		PCF Phone No.

V. 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	Month	Year	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery?	YES	NO	UNK.

Preceding the first positive HIV antibody test or AIDS diagnosis, the child's biological mother had (respond to all categories):	YES	NO	UNK.
• Perinatally acquired HIV infection			
• 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			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)			
First date received: Last date received: Where?			
• Received transplant of tissue/organs or artificial insemination			

Preceding the first positive HIV antibody test or AIDS diagnosis, this child had (respond to all categories):	YES	NO	UNK.
• Injected non-prescription drugs			
• Received clotting factor for hemophilia/coagulation disorder			
Specify clotting factor: Date received (mm/dd/yyyyy):			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)			
First date received: Last date received: Where?			
• Received transplant of tissue/organs			
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?			
• Sexual contact with male			
Is pediatric sexual contact being investigated or considered as primary mode of exposure?			
• Sexual contact with female			
Is pediatric sexual contact being investigated or considered as primary mode of exposure?			
• Other documented risk What is the "other" risk?			
Is other exposure being investigated or considered as primary mode of exposure?			
• No identified risk factor (NIR)			
Date NIR investigation was completed:			

Note: Section IX is presented out of order so as to keep the number of pages at a minimum.

IX. 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:				
• Anti-retroviral therapy for HIV **treatment**	☐ Yes	☐ No	☐ Unknown	
• PCP prophylaxis	☐ Yes	☐ No	☐ Unknown	

Was this 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 time of HIV diagnosis, medical treatment primarily reimbursed by: ☐ Medicaid ☐ Private Insurance ☐ Other ________________ ☐ Unknown

At time of AIDS diagnosis, medical treatment primarily reimbursed by: ☐ Medicaid ☐ Private Insurance ☐ Other ________________ ☐ Unknown

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

VI. Laboratory Data

HIV Antibody Tests at Diagnosis (indicate **first** test—mm/dd/yyyy date)			Record **additional** HIV antibody tests			Collection Date (mm/dd/yyyy)
HIV-1 IFA	☐ Positive	☐ Negative	HIV-1 IFA	☐ Positive	☐ Negative	
HIV-1 Western Blot	☐ Positive	☐ Negative	HIV-1 Western Blot	☐ Positive	☐ Negative	
Rapid	☐ Positive	☐ Negative	Rapid	☐ Positive	☐ Negative	
HIV-1 EIA	☐ Positive	☐ Negative	HIV-1 EIA	☐ Positive	☐ Negative	
HIV-1/2 EIA	☐ Positive	☐ Negative	HIV-1/2 EIA	☐ Positive	☐ Negative	
HIV-2 EIA	☐ Positive	☐ Negative	HIV-2 EIA	☐ Positive	☐ Negative	
HIV-2 Western Blot	☐ Positive	☐ Negative	HIV-2 Western Blot	☐ Positive	☐ Negative	

HIV Detection Tests (record all tests—mm/dd/yyyy date)

HIV-1 P24 Antigen	☐ Pos	☐ Neg	HIV-1 P24 Antigen	☐ Pos	☐ Neg
HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg	HIV-1 RNA PCR (Qual)	☐ Pos	☐ Neg
HIV-1 Culture	☐ Pos	☐ Neg	HIV-1 Culture	☐ Pos	☐ Neg
HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg	HIV-1 Proviral DNA (Qual)	☐ Pos	☐ Neg
HIV-2 Culture	☐ Pos	☐ Neg	HIV-2 Culture	☐ Pos	☐ Neg

Immunologic Lab Tests (record additional CD4 tests in Comments section) Collection Date (mm/dd/yyyy)

At or closest to current diagnostic status	CD4 count	cells/µL	
	CD4 percent	%	
First <200µL or <14%	CD4 count	cells/µL	
	CD4 percent	%	

Viral Load Tests (record most recent test or 1st reportable test; record additional viral load tests in Comments section)

	Copies/µL	Log	Collection Date (mm/dd/yyyy)
HIV-1 RNA NASBA			
HIV-1 RNA RT-PCR			
HIV-1 RNA bDNA			
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 AIDS case definition? ☐ Yes ☐ No ☐ Unknown

Was patient confirmed by a physician as:

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

VII. Clinical Status

AIDS Indicator Diseases (Def. = definitive)	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy	AIDS Indicator Diseases (Pres. = presumptive)	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy
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) onset at >1 mo. of age				M. tuberculosis, disseminated or extrapulmonary			
Cytomegalovirus retinitis (with loss of vision)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
HIV encephalopathy				Pneumocystis carinii pneumonia			
Herpes simplex: chronic ulcers (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 mo. of age				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? ☐ Yes ☐ No ☐ Unknown

If **Yes**, initial diagnosis and date: ☐ TB pre-1993 ☐ Presumptive ☐ Definitive ☐ Unknown (mm/dd/yyyy)

RVCT Case Number

VIII. Birth History (for PERINATAL cases only)

Birth history available for this child: ☐ Yes ☐ No ☐ Unknown If **No** or **Unknown**, do not complete this section.

Residence at Birth ☐ Same as current residential address

Address	City	County	State/Country	ZIP Code

Hospital at Birth

Facility Name	Phone Number

Address	City	County	State/Country	ZIP Code

Birthweight (enter lbs/oz OR grams)
lbs oz
grams

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: Code: .
Specify: Code: .

Neonatal Status: ☐ Full term ☐ Premature No. of weeks (gestational age): (99 = Unknown)

Prenatal Care—Month of pregnancy when prenatal care began: (99 = Unknown) (00 = None)

Prenatal Care—Total number of prenatal care visits: (99 = Unknown) (00 = None)

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

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

Did mother receive any **other** antiretroviral medication **during pregnancy**? ☐ Yes ☐ No ☐ Refused
If **Yes**, specify:

If **Yes**, week of pregnancy when zidovudine (ZDV, AZT) began: Week (99 = Unknown) ____________________

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

Did mother receive any **other** antiretroviral medication **during labor/delivery?** ☐ Yes ☐ No ☐ Refused
If **Yes**, specify:

Maternal Date of Birth	Maternal Soundex

Maternal State Patient Number

Birthplace of Biological Mother

☐ U.S. ☐ U.S. Minor Outlying Area: (specify)

☐ Unknown ☐ Other: (specify)

X. Comments

SSN:

Who is/was the pediatrician after birth?

What info is available on the father of this child? (Name? DOB? HIV status?)

For HIV exposed babies: Will baby be referred to USF Immunology Pediatric Clinic? If not, where?

For HIV exposed babies: Was the baby also exposed to hepatitis, STDs, or any other diseases?

Please provide baby/child caretaker information, if other than the biological parent: (Name?)

(Please use additional pages, as needed)

XI. Local Fields

CONTACT STATENO(S):	
EPF_____ EPF DATE __________________	
OTHER RISKS: A____ B/C____ D____ F____ M____ V___	
HEPATITIS: A____ B____ C____ Other____ Unknown____	
NIR STATUS: NIR_OP____ NIR OP DATE __________________	
NIR_CL____ NIR CL DATE __________________	
NIR_RE____ NIR RE DATE _______________ INITIALS_______	**SOURCE CODE A__________**