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)

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

Patient's Name	Alias	Phone No.

Address	City	County	State	ZIP Code

_____ Date form completed | Document source _____ or source code: **A** _____ . _____ . _____ . _____

II. Health Department Use Only

Soundex Code	Does this report initiate a new case investigation or an update on a case?	Reporting Health Department SNHD	State Patient Number
	☑ New ☐ Update	State NV	
Surveillance Method		City/County Clark	Social Security Number (no dashes)
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
- ☐ Perinatal HIV Exposure
- ☐ Pediatric HIV
- ☐ Pediatric AIDS
- ☐ Pediatric Seroreverter

Date of Last Medical Evaluation			Date of Birth			Age at HIV Diagnosis (not AIDS)	
Month	Day	Year	Month	Day	Year	Years	Months
Date of Initial Evaluation for HIV			**Alias Date of Birth**			**Age at AIDS Diagnosis**	
Month	Day	Year	Month	Day	Year	Years	Months

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

Marital Status
- ☐ Married and separated
- ☐ Divorced
- ☐ Married
- ☐ Single and never married
- ☐ Widowed
- ☐ Unknown
- ☐ Other
- ☐ Not specified

Education
- ☐ 8th grade or less
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college
- ☐ College degree
- ☐ Post-graduate work
- ☐ Some school, level unknown
- ☐ Unknown

Sex at Birth
- ☐ Male
- ☐ Female
- ☐ Unknown

Current Sex
- ☐ Male
- ☐ Female
- ☐ Intersexed

Gender
- ☐ Male
- ☐ Female
- ☐ Male to Female
- ☐ Female to Male
- ☐ Intersexed
- ☐ She Male
- ☐ Cross Dresser
- ☐ Drag Queen

Vital Status
- ☐ Alive
- ☐ Dead
- ☐ Unknown

Date of Death			State/Territory of Death
Month	Day	Year	

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

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

Ethnicity
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

Extended Ethnicity

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Unknown

Extended Race

Residence at Diagnosis ☐ Same address as patient address

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
- ☐ Public ☐ County
- ☐ Federal ☐ City
- ☐ State ☐ Private

Specify setting, if **Federal**:

Facility Type
- ☐ Inpatient Facility ☐ Laboratory
- ☐ Outpatient Facility ☐ Other
- ☐ Emergency Room ☐ Unknown
- ☐ Screening, Diagnostic, Referral Agency

Specify type of facility:

HRSA Funding
- ☐ 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 | 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:			
o Intravenous/injection drug user			
o Bisexual male			
o Male with hemophilia/coagulation disorder			
o Transfusion recipient with documented HIV infection			
o Transplant recipient with documented HIV infection			
o 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:			
• 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/yyyy):			
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)	☐	☐	☐
First date received: Last date received:			
• 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	☐	☐	☐
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:

At time of AIDS diagnosis, medical treatment primarily reimbursed by:

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

VI. Laboratory Data

HIV Antibody Tests at Diagnosis (indicate first test—mm/dd/yyyy date)

HIV-1 IFA	☐ Positive	☐ Negative	
HIV-1 Western Blot	☐ Positive	☐ Negative	
Rapid	☐ Positive	☐ Negative	
HIV-1 EIA	☐ Positive	☐ Negative	
HIV-1/2 EIA	☐ Positive	☐ Negative	
HIV-2 EIA	☐ Positive	☐ Negative	
HIV-2 Western Blot	☐ Positive	☐ Negative	

Record additional HIV antibody tests — Collection Date (mm/dd/yyyy)

HIV-1 IFA	☐ Positive	☐ Negative	
HIV-1 Western Blot	☐ Positive	☐ Negative	
Rapid	☐ Positive	☐ Negative	
HIV-1 EIA	☐ Positive	☐ Negative	
HIV-1/2 EIA	☐ Positive	☐ Negative	
HIV-2 EIA	☐ Positive	☐ Negative	
HIV-2 Western Blot	☐ Positive	☐ Negative	

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

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

Address	City	County	State/Country	ZIP Code

Hospital at Birth

Facility Name Phone Number

Address	City	County	State/Country	ZIP Code

Birth weight (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: Specify:

Code: . 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

XI. Local Fields

If individual reports a previous/concurrent STD diagnosis, check all that apply □ CT □ GC □ Syphilis □Unspecified	
If individual reports a previous/concurrent Hepatitis diagnosis, check all that apply □ A □ B □C □Other □Unspecified	
HIV Bubble Sheet ID Number =	
HIV Bubble Sheet Test Date (mm/yyyy) =	
Is this individual enrolled in the AIDS Drug Assistance Program (ADAP)? □Yes □No □Unknown	