Pediatric HIV/AIDS Confidential Case Report
(for patients < 13 years of age at time of diagnosis)
Return completed form to state/local health department

_____ Date received at Health Department (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

Address Type

□ Residence at HIV Diagnosis
□ Residence at AIDS Diagnosis
□ Residence at Perinatal Exposure
□ Residence at Pediatric Seroreverter
□ Check of Same as Current Address

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

II. Health Department Use Only

Soundex Code	Did this report initiate a new case investigation?	Reporting Health Department	State Patient Number
	■ Yes □ No	SNHD	

Surveillance Method					City/County	Social Security Number (no dashes)
A	F	P	R	U	Clark	

Report Medium	Field Visit	Mailed	Faxed	Phone	E. Transfer	Diskette

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

III. Demographic Information

Diagnostic Status at Report	Age at Diagnosis	Date of Birth			Alias Date of Birth			Sex at Birth	Country of Birth
☐ Perinatal HIV Exposure ☐ Pediatric HIV	Years (HIV)	Month	Day	Year	Month	Day	Year	☐ Male ☐ Female ☐ Unknown	☐ U.S. ☐ Other Specify, if **Other**:
☐ Pediatric AIDS ☐ Pediatric Seroreverter	Years (AIDS)								

Current Sex	Vital Status	Date of Death			State/Territory of Death
☐ Male ☐ Female ☐ Intersexed	☐ Alive ☐ Dead ☐ Unknown	Month	Day	Year	Was reason for initial HIV evaluation due to clinical signs and symptoms? ☐ Yes ☐ No ☐ Unknown

Date of Last Medical Review (mm/dd/yyyy) _____/_____/_____

Date of Initial Evaluation for HIV (mm/dd/yyyy) _____/_____/_____

Ethnicity	Extended Ethnicity	Race		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

Address	City	County	State/Country	ZIP Code

IV. Facility and Provider of Diagnosis / Facility of Care

☐ Pediatric HIV diagnosis
☐ Pediatric AIDS diagnosis
☐ Facility/Provider of care
☐ Perinatal HIV Exposure
☐ Pediatric Seroreverter

Facility Name

Address	City	County	State/Country	ZIP Code

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

Provider Name	Provider Specialty
Provider Phone No. / Medical Record No.	
Person Completing Form	Phone No.

V. Patient History

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	☐ Yes ☐ No ☐ Unknown
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received _____/_____/_____ Last date received _____/_____/_____	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?	☐ Yes ☐ No ☐ Unknown
Before the diagnosis of HIV infection, this child had:	
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder Specify clotting factor: Date received:	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received Last date received	
Received transplant of tissue/organs	☐ Yes ☐ No ☐ Unknown
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Is pediatric sexual contact with male being investigated or considered as primary mode of exposure?	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Is pediatric sexual contact with female being investigated or considered as primary mode of exposure?	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown
Is other documented risk being investigated or considered as primary mode of exposure?	☐ Yes ☐ No ☐ Unknown
No identified risk (NIR) Date NIR investigation was completed: (mm/dd/yyyy) _____/_____/_____	☐ Yes ☐ No ☐ Unknown

VI. Laboratory Data

HIV Immunoassays (Non-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** ____ / ____/_____ ☐ Rapid Test (check if rapid)

TEST 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** ____ / ____/_____ ☐ Rapid Test (check if rapid)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)

Test Brand Name/Manufacturer:_____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: ____ / ____/_____ ☐ Rapid Test (check if rapid)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)

Test Brand Name/Manufacturer:_____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: ____ / ____/_____ ☐ Rapid Test (check if rapid)

□ 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** □ Reactive □ Nonreactive □ Not Reported **HIV-Ab** □ HIV-1 Reactive □ HIV-2 Reactive □ Both Reactive, Undifferentiated □ Both Nonreactive

*Select one result for HIV-1 Ag and one result for HIV Ab

Collection Date: ____ / ____/_____

HIV Detection Tests (Qualitative)

TEST: □ HIV-1 RNA/DNA NAAT (Qual) □ HIV-1 Culture □ HIV-2 RNA/DNA NAAT (Qual) □ HIV-2 Culture

RESULT: □ Positive/Reactive □ Negative/Nonreactive □ Indeterminate **Collection Date:** ____ / ____/_____

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

TEST 1: □ HIV-1 RNA/DNA NAAT (Quantitative viral load) □ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: □ Detectable □ Undetectable **Copies/mL:** Log: **Collection Date:** ____ / ____/_____

TEST 2: □ HIV-1 RNA/DNA NAAT (Quantitative viral load) □ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: □ Detectable □ Undetectable **Copies/mL:** Log: **Collection Date:** ____ / ____/_____

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count: cells/µL **CD4 percentage:** % **Collection Date:** / /

First CD4 result <200 cells/µL or <14%: CD4 count: cells/µL **CD4 percentage**: % **Collection Date:** / /

Other CD4 result: CD4 count: cells/µL **CD4 percentage:** % **Collection Date:** / /

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? □ Yes □ No □ 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 HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? □ Yes □ No □ Unknown
If YES, provide date of diagnosis: ____ / ____/_____

Date of last documented negative HIV test (before HIV diagnosis date): ____ / ____/_____ Specify type of test:

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

Clinical Record Reviewed □ Yes □ No

Enter date patient was diagnosed as: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy) mm/dd/yyyy; Symptomatic (not AIDS) mm/dd/yyyy

HIV Stage 3 (AIDS) Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy	HIV Stage 3 (AIDS) Indicator Diseases	Initial Dx Def.	Initial Dx Pres.	Initial Date mm/dd/yyyy
Candidiasis, bronchi, trachea, or lungs				Lymphoma, Burkitt's (or equivalent)			
Candidiasis, esophageal				Lymphoma, immunoblastic (or equivalent)			
Carcinoma, invasive cervical				Lymphoma, primary in brain			
Coccidioidomycosis, disseminated or extrapulmonary				Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary			
Cryptococcosis, extrapulmonary				M. tuberculosis, pulmonary			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				M. tuberculosis, disseminated or extrapulmonary			
Cytomegalovirus disease (other than in liver, spleen, or nodes)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
Cytomegalovirus retinitis (with loss of vision)				Pneumocystis carinii pneumonia			
HIV encephalopathy				Pneumonia, recurrent, in 12 mo. period			
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis				Progressive multifocal leukoencephalopathy			
Histoplasmosis, disseminated or extrapulmonary				Salmonella septicemia, recurrent			
Isosporiasis, chronic intestinal (>1 mo. duration)				Toxoplasmosis of brain, onset at >1 mo. of age			
Kaposi's sarcoma				Wasting syndrome due to HIV			
Lymphoid interstitial pneumonia and/or pulmonary lymphoid				Def. = definitive diagnosis			Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis? ☐ Yes ☐ No ☐ Unknown

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

RVCT Case Number | | | | | | | | | |

If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition: □ Yes □ No □ Unknown

VIII. Treatment/Services Referrals

Has this patient been informed of his/her HIV infection?		☐ Yes ☐ No ☐ Unknown	This patient's partners will be notified about their HIV exposure and counseled by:		☐ Health Department ☐ Physician/Provider ☐ Patient ☐ Unknown
This patient is receiving or has been referred for:	HIV related medical services	☐ Yes ☐ No ☐ Unknown	This patient received or is receiving:	Antiretroviral therapy	☐ Yes ☐ No ☐ Unknown
	Substance abuse treatment services	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown		PCP prophylaxis	☐ 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:	None		At time of AIDS diagnosis, medical treatment primarily reimbursed by:		
Was this child breastfed? ☐ Yes ☐ No ☐ Unknown					
This child's primary caretaker is:	☐ 1- Biological Parent ☐ 2- Other Relative ☐ 3- Foster/Adoptive parent, relative ☐ 4- Foster/Adoptive parent, unrelated ☐ 7- Social Service Agency ☐ 8- Other (please specify in comments) ☐ 9- Unknown				

IX. HIV Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one): ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E ☐ Other	Date patient reported information __ __ /__ __/

This child received or is receiving:

Neonatal ARVs for HIV prevention: ☐ Yes ☐ No ☐ Unknown	Date began:__ __ /__ __/__ __ __ __	Date of last use: __ __ /__ __/		
If Yes, please specify: 1)	2)	3)	4)	5)
Anti-retroviral therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown	Date began: __ __ /__ __/__ __ __ __	Date of last use:__ __ /__ __/		
PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown	Date began:__ __ /__ __/__ __ __ __	Date of last use: __ __ /__ __/		

X. Birth History (record all dates as mm/dd/yyyy)

Residence at Birth

Birth History Available ☐ Yes ☐ No ☐ Unknown	☐ Check if SAME as Current Address		
*Street Address	City		
County	State/Country	*ZIP Code	

Facility of Birth

☐ 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 Unknown	*Inpatient:* ☐ Hospital ☐ Other, specify_____	*Outpatient* ☐ Other, specify _____	*Other Facility*: ☐ Emergency Room ☐ Corrections ☐ Other, specify _____
*Street Address	City	County	State/Country

Birth History

Birth Weight _____lbs _____oz _____grams	Type ☐ 1-Single ☐ 2-Twin ☐ 3->2 ☐ 9-Unknown	Delivery ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Non-Elective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown	
Birth Defects ☐ Yes ☐ No ☐ Unknown	If yes, please specify:		
Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ 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? ☐ Yes ☐ No ☐ Refused ☐ Unknown	If yes, please specify all:		
Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Unknown	If yes, please specify all:		
Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ 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		

XI. Comments

XII. Local Fields		
If individual reports a previous/concurrent STD diagnosis, select type	☐ CT ☐ GC ☐ Syphilis ☐ Unspecified	
If individual reports a previous/concurrent Hepatitis diagnosis, select type	☐ 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	