



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					
<input type="checkbox"/> Residence at HIV Diagnosis		<input type="checkbox"/> Residence at Perinatal Exposure		<input type="checkbox"/> Check of Same as Current Address	
<input type="checkbox"/> Residence at AIDS Diagnosis		<input type="checkbox"/> Residence at Pediatric Seroreverter			

_____ 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 <input type="checkbox"/> No		SNHD							
Surveillance Method				City/County				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 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		
Pediatric AIDS Pediatric Seroreverter		Years (AIDS)										Specify, if Other :	
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?						
							<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
		Date of Last Medical Review (mm/dd/yyyy) ____/____/____											
		Date of Initial Evaluation for HIV (mm/dd/yyyy) ____/____/____											
Ethnicity		Extended Ethnicity		Race			Native Hawaiian			Extended Race			
Hispanic/Latino Not Hispanic/Latino Unknown				American Indian or Alaska Native Asian Black or African American			White Unknown						

Residence at Diagnosis ☐ Same address as patient address

Address		City	County	State/Country	ZIP Code
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IV. Facility and Provider of Diagnosis / Facility of Care

<input type="checkbox"/> Pediatric HIV diagnosis <input type="checkbox"/> Pediatric AIDS diagnosis		<input type="checkbox"/> Facility/Provider of care <input type="checkbox"/> Perinatal HIV Exposure <input type="checkbox"/> 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	
<input type="checkbox"/> Public <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Private				<input type="checkbox"/> Inpatient Facility <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Emergency Room <input type="checkbox"/> Private Physician		<input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Laboratory <input type="checkbox"/> Other <input type="checkbox"/> Unknown		<input type="checkbox"/> None <input type="checkbox"/> Title I <input type="checkbox"/> Title II <input type="checkbox"/> Title III <input type="checkbox"/> Title IV <input type="checkbox"/> SPNS <input type="checkbox"/> Other <input type="checkbox"/> 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): <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> Known HIV+ at delivery <input type="checkbox"/> Known HIV+ after child's birth <input type="checkbox"/> HIV+, time of diagnosis unknown <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____/____/____ Last date received ____/____/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?	<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	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?	<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
Is pediatric sexual contact with male being investigated or considered as primary mode of exposure?	<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
Is pediatric sexual contact with female being investigated or considered as primary mode of exposure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <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 <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not Reported		HIV-Ab <input type="checkbox"/> HIV-1 Reactive <input type="checkbox"/> HIV-2 Reactive <input type="checkbox"/> Both Reactive, Undifferentiated <input type="checkbox"/> Both Nonreactive	
*Select one result for HIV-1 Ag and one result for HIV Ab			
Collection Date: ____ / ____ / ____			
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/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? <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 HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Was patient confirmed by a physician as: HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes , enter date of diagnosis (mm/dd/yyyy): ____ / ____ / ____	
Not HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes , enter date of diagnosis (mm/dd/yyyy): ____ / ____ / ____	

VII. Clinical Status													
Clinical Record <input type="checkbox"/> Yes Reviewed <input type="checkbox"/> No		Enter date patient was diagnosed as: _____		<u>Asymptomatic</u> (including acute retroviral syndrome and persistent generalized lymphadenopathy)			mm/dd/yyyy		<u>Symptomatic</u> (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/identified 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If Yes , initial diagnosis and date: ____ / ____ / ____				<input type="checkbox"/> TB pre-1993 <input type="checkbox"/> Definitive <input type="checkbox"/> Presumptive				<input type="checkbox"/> 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:				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					

VIII. Treatment/Services Referrals					
Has this patient been informed of his/her HIV infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	This patient's partners will be notified about their HIV exposure and counseled by:		<input type="checkbox"/> Health Department <input type="checkbox"/> Physician/Provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown
This patient is receiving or has been referred for:	HIV related medical services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antiretroviral therapy		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Substance abuse treatment services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	This patient received or is receiving: PCP prophylaxis		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
This patient has been enrolled at (clinical trial):	<input type="checkbox"/> NIH Sponsored <input type="checkbox"/> Other	<input type="checkbox"/> None <input type="checkbox"/> Unknown	This patient has been enrolled at (clinic):		<input type="checkbox"/> HRSA Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown
At time of HIV diagnosis, medical treatment primarily reimbursed by:			At time of AIDS diagnosis, medical treatment primarily reimbursed by:		
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					

IX. HIV Antiretroviral Use History (record all dates as mm/dd/yyyy)	
Main source of antiretroviral (ARV) use information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review <input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E <input type="checkbox"/> Other	Date patient reported information ____/____/____
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: ____/____/____	

X. Birth History (record all dates as mm/dd/yyyy)			
Residence at Birth			
Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Check if <u>SAME as Current Address</u>	
*Street Address		City	
County	State/Country	*ZIP Code	
Facility of Birth			
<input type="checkbox"/> Check if <u>SAME as Facility Providing Information</u>			
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone () _____	*ZIP Code
Facility Type	<u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient	<u>Other Facility:</u> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Corrections	
Unknown	<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Other, specify _____	<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 – Total number of prenatal care visits: _____ (00-None, 99-Unknown)	
Prenatal Care Began (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	

XI. Comments	

XII. Local Fields		
If individual reports a previous/concurrent STD diagnosis, select type	<input type="checkbox"/> CT <input type="checkbox"/> GC <input type="checkbox"/> Syphilis <input type="checkbox"/> Unspecified	
If individual reports a previous/concurrent Hepatitis diagnosis, select type	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other <input type="checkbox"/> Unspecified	
HIV Bubble Sheet ID Number =		
HIV Bubble Sheet Test Date (mm/yyyy)		
Is this individual enrolled in the AIDS Drug Assistance Program (ADAP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	