

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: () _____
 (Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip: _____
 Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

- Patient identifier information is not transmitted to CDC! -

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
 Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
 (Patients <13 years of age at time of diagnosis)



DATE FORM COMPLETED:

Mo. Day Yr.

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

REPORT SOURCE:

SOUNDEX CODE: <input type="text"/> <input type="text"/> <input type="text"/>	REPORT STATUS: <input type="checkbox"/> 1 New Report <input type="checkbox"/> 2 Update	REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____	State Patient No.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	City/County Patient No.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) <input type="checkbox"/> 3 Perinatally HIV Exposed <input type="checkbox"/> 4 Confirmed HIV Infection (not AIDS)		<input type="checkbox"/> 5 AIDS <input type="checkbox"/> 6 Seroreverter		DATE OF LAST MEDICAL EVALUATION: Mo. Yr. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
DATE OF BIRTH: Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	AGE AT DIAGNOSIS: Years Months HIV Infection (not AIDS) ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> AIDS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CURRENT STATUS: <input type="checkbox"/> 1 Alive <input type="checkbox"/> 2 Dead <input type="checkbox"/> 9 Unk.	DATE OF DEATH: Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	STATE/TERRITORY OF DEATH: _____	DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	SEX: <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	ETHNICITY: (select one) <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 2 Not Hispanic or Latino <input type="checkbox"/> 9 Unk.	RACE: (select one or more) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk	COUNTRY OF BIRTH: <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ <input type="checkbox"/> 8 Other (specify): _____ <input type="checkbox"/> 9 Unk.	
RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/Country: _____

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 88 Other (specify): _____

V. PATIENT/MATERNAL HISTORY (Respond to ALL categories)

• **Child's biologic mother's HIV Infection Status:** (check one)
 1 Refused HIV testing 2 Known to be uninfected after this child's birth 9 HIV status unknown

Diagnosed with HIV Infection/AIDS:
 3 Before this child's pregnancy 5 At time of delivery 7 After the child's birth
 4 During this child's pregnancy 6 Before child's birth, exact period unknown 8 HIV-infected, unknown when diagnosed

Mo. Yr.

• **Date of mother's first positive HIV confirmatory test:** _____

• **Mother was counseled about HIV testing during this pregnancy, labor or delivery?** Yes No Unk.
 1 0 9

After 1977, this child's biologic mother had:	Before the diagnosis of HIV Infection/AIDS, this child had:
• Injected nonprescription drugs <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • HETEROSEXUAL relations with: - Intravenous/injection drug user <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 - Bisexual male <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 - Male with hemophilia/coagulation disorder <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 - Transfusion recipient with documented HIV infection <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 - Transplant recipient with documented HIV infection <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 - Male with AIDS or documented HIV infection, risk not specified .. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transfusion of blood/blood components (other than clotting factor) <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transplant of tissue/organs or artificial insemination <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	• Received clotting factor for hemophilia/coagulation disorder <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 (specify <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) disorder): <input type="checkbox"/> 8 Other (specify): _____ • Received transfusion of blood/blood components (other than clotting factor) <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 Mo. Yr. Mo. Yr. First: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Last: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> • Received transplant of tissue/organs <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Sexual contact with a male <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Sexual contact with a female <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Injected nonprescription drugs <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Other (Alert State/City NIR Coordinator) <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: () _____ Medical Record No. _____
 (Last, First, M.I.)
 Hospital/Facility: _____ Person Completing Form: _____ Phone No.: () _____
 - Physician identifier information is not transmitted to CDCI -

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE	
					Mo.	Yr.
• HIV-1 EIA	1	0	-	9		
• HIV-1 EIA	1	0	-	9		
• HIV-1/HIV-2 combination EIA	1	0	-	9		
• HIV-1/HIV-2 combination EIA	1	0	-	9		
• HIV-1 Western blot/IFA	1	0	8	9		
• HIV-1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify):	1	0	8	9		

2. HIV DETECTION TESTS: (Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE	
				Mo.	Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify	1	0	9		

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable		Copies/ml	Test Date	
	Yes	No		Mo.	Yr.
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

	Mo.	Yr.
• CD4 Count		
• CD4 Count		
• CD4 Percent		
• CD4 Percent		

5. 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 Unk. 1 0 9

6. If laboratory tests were not documented, is patient confirmed by a physician as: Yes No Unk. Date of Documentation Mo. Yr.

• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES		Initial Diagnosis		Initial Date		AIDS INDICATOR DISEASES		Initial Diagnosis		Initial Date				
	Def.	Pres.	Mo.	Yr.		Def.	Pres.	Mo.	Yr.		Def.	Pres.	Mo.	Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA			Kaposi's sarcoma	1	2							
Candidiasis, bronchi, trachea, or lungs	1	NA			Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2							
Candidiasis, esophageal	1	2			Lymphoma, Burkitt's (or equivalent term)	1	NA							
Coccidioidomycosis, disseminated or extrapulmonary	1	NA			Lymphoma, immunoblastic (or equivalent term)	1	NA							
Cryptococcosis, extrapulmonary	1	NA			Lymphoma, primary in brain	1	NA							
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA			Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1	2							
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA			M. tuberculosis, disseminated or extrapulmonary*	1	2							
Cytomegalovirus retinitis (with loss of vision)	1	2			Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2							
HIV encephalopathy	1	NA			Pneumocystis carinii pneumonia	1	2							
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA			Progressive multifocal leukoencephalopathy	1	NA							
Histoplasmosis, disseminated or extrapulmonary	1	NA			Toxoplasmosis of brain, onset at >1 mo. of age	1	2							
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			Wasting syndrome due to HIV	1	NA							

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. *RVCT CASE NO.:

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: 1 Yes 0 No 9 Unk. *If No or Unknown, proceed to Section X.*

HOSPITAL AT BIRTH:

Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/Country: _____ Zip Code: _____

BIRTHWEIGHT:
(enter lbs/oz OR grams)

____ lbs. ____ oz

____ grams

BIRTH: Type: 1 Single 2 Twin 3 >2 9 Unk.

Delivery: 1 Vaginal 2 Elective Caesarean 3 Non-elective Caesarean
 4 Caesarean, unk. type 9 Unk.

Birth Defects: 1 Yes 0 No 9 Unk.
Specify type(s): _____ Code: _____

NEONATAL STATUS:

1 Full term
 2 Premature
Weeks: _____
99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: _____ mos.
99 = Unk. 00 = None
Total number of prenatal care visits: _____
99 = Unk. 00 = None

• Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused Yes No Unk.
 8 1 0 9

• Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Refused Yes No Unk.
 8 1 0 9

• If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: _____
99 = Unk.

• Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes No Unk.
 1 0 9

• Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unk.
 1 0 9
If yes, specify: _____

• Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unk.
 1 0 9
If yes, specify: _____

Maternal Date of Birth

Mo. Day Yr.

Maternal Soundex:

Maternal State Patient No.

Birthplace of Biologic Mother:

1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
 8 Other (specify): _____ 9 Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

• Neonatal zidovudine (ZDV, AZT) for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.
 1 0 9 _____

• Other neonatal anti-retroviral medication for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.
 1 0 9 _____

• Anti-retroviral therapy for HIV treatment Yes No Unk. DATE STARTED Mo. Day Yr.
 1 0 9 _____

• PCP prophylaxis Yes No Unk. DATE STARTED Mo. Day Yr.
 1 0 9 _____

If yes, specify: _____

Was child breastfed?

Yes No Unk.
 1 0 9

This child has been enrolled at:

Clinical Trial **Clinic**
 1 NIH-sponsored 2 Other 1 HRSA-sponsored 2 Other
 3 None 9 Unk. 3 None 9 Unk.

This child's medical treatment is primarily reimbursed by:

1 Medicaid 4 Other Public Funding
 2 Private insurance/HMO 7 Clinical trial/government program
 3 No coverage 9 Unk.

This child's primary caretaker is:

1 Biologic parent(s) 2 Other relative 3 Foster/Adoptive parent, relative 4 Foster/Adoptive parent, unrelated 7 Social service agency 8 Other (specify in Section XI.) 9 Unk.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.

XI. COMMENTS (continued)

Lined area for writing comments.