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)

CDC Centers for Disease Control and Prevention

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

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

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT:
State: _____
City/ County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)
3 Perinatally HIV Exposed; 4 Confirmed HIV Infection (not AIDS); 5 AIDS; 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months
HIV Infection (not AIDS) ...
AIDS .....

CURRENT STATUS: 1 Alive; 2 Dead; 9 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes 1 No 0 Unk. 9

SEX: 1 Male; 2 Female

ETHNICITY: (select one)
1 Hispanic; 2 Not Hispanic or Latino; 9 Unk.

RACE: (select one or more)
American Indian/ Alaska Native; Native Hawaiian or Other Pacific Islander; Asian; White; Black or African American; Unk

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

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/ Country: _____ Zip Code: _____

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 **un**infected after this child's birth; 9 HIV status unknown

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

• **Date of mother's first positive HIV confirmatory test:** ..... Mo. Yr.

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

After 1977, this child's biologic mother had: Yes No Unk.
- Injected nonprescription drugs 1 0 9
- *HETEROSEXUAL* relations with:
  - Intravenous/injection drug user 1 0 9
  - Bisexual male 1 0 9
  - Male with hemophilia/coagulation disorder 1 0 9
  - Transfusion recipient with documented HIV infection 1 0 9
  - Transplant recipient with documented HIV infection 1 0 9
  - Male with AIDS or documented HIV infection, risk not specified .. 1 0 9
- Received transfusion of blood/blood components (other than clotting factor) 1 0 9
- Received transplant of tissue/organs or artificial insemination 1 0 9

Before the diagnosis of HIV Infection/AIDS, this child had: Yes No Unk.
- Received clotting factor for hemophilia/coagulation disorder 1 0 9
  (specify disorder): 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____
- Received transfusion of blood/blood components (other than clotting factor) 1 0 9
  First: Mo. Yr. Last: Mo. Yr.
- Received transplant of tissue/organs 1 0 9
- Sexual contact with a male 1 0 9
- Sexual contact with a female 1 0 9
- Injected nonprescription drugs 1 0 9
- Other (Alert State/City NIR Coordinator) 1 0 9

VI. STATE/LOCAL USE ONLY

Physician's Name: (Last, First, M.I.) _____ Phone No.: ( ) _____ Medical Record No. _____

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

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

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE 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.	TEST DATE 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 Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

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

	Mo.	Yr.
• CD4 Count _____ , _____ cells/µL		
• CD4 Count _____ , _____ cells/µL		
• 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 1 No 0 Unk. 9

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii,* disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
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 [8] Yes [1] No [0] Unk. [9]
- **Did mother receive zidovudine (ZDV, AZT) during labor/delivery?** Refused [8] Yes [1] No [0] Unk. [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 [1] No [0] Unk. [9]
- **Did mother receive any other Anti-retroviral medication during pregnancy?** Yes [1] No [0] Unk. [9] If yes, specify: _____
- **Did mother receive any other Anti-retroviral medication during labor/delivery?** Yes [1] No [0] Unk. [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:

	Yes	No	Unk.	DATE STARTED Mo. Day Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	[1]	[0]	[9]	_____
• Other neonatal anti-retroviral medication for HIV *prevention*	[1]	[0]	[9]	_____
• Anti-retroviral therapy for HIV *treatment*	[1]	[0]	[9]	_____
• PCP prophylaxis	[1]	[0]	[9]	_____

If yes, specify: _____

Was child breastfed? Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial: [1] NIH-sponsored [2] Other [3] None [9] Unk.

Clinic: [1] HRSA-sponsored [2] Other [3] None [9] Unk.

This child's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO [3] No coverage [4] Other Public Funding [7] Clinical trial/government program [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)

XI. COMMENTS (continued)

RACE/ETHNIC BACKGROUND FORM
FOR ASIANS OR HAWAIIAN/ PACIFIC ISLANDERS

Please mark ALL *the appropriate boxes with an X.*

ASIANS:

01	Japanese
02	Filipino
03	Chinese
06	Korean
17	Vietnamese
18	Laotian
19	Thai
20	Cambodian
21	Indonesian
22	Asian Indian
23	Other Asian
24	Pakistani
25	Malaysian

HAWAIIAN / PACIFIC ISLANDERS:

04	Hawaiian
07	Samoan
08	Guamanian
09	Tongan
10	Fijian
11	Marshallese
12	Micronesian
13	Tahitian
14	Northern Mariana
15	Palauan
16	Other Pac. Islander
26	Polynesian