

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≤ 12 years of age at time of diagnosis)

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

Patient's name (last, first, MI)			Telephone number () () ()		Social Security Number	
Address (number, street)			City		County	
			State		ZIP code	
Date form completed (mm/dd/yyyy)		II. Health Department Use Only				
Report status <input type="checkbox"/> 1 New <input type="checkbox"/> 2 Update		Report source	Reporting health department		State patient number	City/county patient number
Soundex code	Date of birth (mm/dd/yyyy)		Gender	CLIA number	Lab report/Accession number	*Confidential C&T number
	Month Day Year 		<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female			

III. Demographic Information					
Diagnosis status at report (check one)		Age at Diagnosis Years Months	Current status	Date of death Month Day Year	
<input type="checkbox"/> 3 Perinatally HIV exposed.....			<input type="checkbox"/> 1 Alive <input type="checkbox"/> 2 Dead <input type="checkbox"/> 9 Unknown		
<input type="checkbox"/> 4 Confirmed HIV infection (not AIDS)..			Was reason for initial HIV evaluation due to clinical signs and symptoms? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown		
<input type="checkbox"/> 5 AIDS.....					
<input type="checkbox"/> 6 Seroreverter.....			Date of initial evaluation for HIV infection Month Day Year 		
			Date of last medical evaluation Month Day Year 		
ETHNICITY		RACE		COUNTRY OF BIRTH	
<input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 2 Not Hispanic nor Latino		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black or African American		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Territories (including Puerto Rico) <input type="checkbox"/> 8 Other (specify): _____ <input type="checkbox"/> 9 Unknown	
Expanded race (specify): _____					
<input type="checkbox"/> Check here if HIV infection is presumed to have been acquired outside United States and Territories. Specify country: _____					
Residence at first diagnosis of HIV or AIDS: <input type="checkbox"/> Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.)					
City		County		State/Country	
				ZIP code	

IV. Facility of Diagnosis (LHDs use approved abbreviations from "Facility List.")			
Facility name		City	State/Country
Facility setting (check one)	Facility type (check one)		
<input type="checkbox"/> 1 Public <input type="checkbox"/> 2 Private <input type="checkbox"/> 3 Federal <input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 01 Physician, HMO <input type="checkbox"/> 22 Counseling and Testing Site <input type="checkbox"/> 29 Community Health Center <input type="checkbox"/> 30 Correctional Facility <input type="checkbox"/> 31 Hospital, inpatient <input type="checkbox"/> 32 Hospital, outpatient <input type="checkbox"/> 88 Other (specify): _____ <input type="checkbox"/> 99 Unknown		

V. Patient/Maternal Risk History (Respond to all categories.)					
Child's biological mother's HIV infection status (check one)					
HIV negative or no diagnosis:			HIV positive or AIDS diagnosis:		
<input type="checkbox"/> 1 Refused HIV testing <input type="checkbox"/> 2 Known to be uninfected after this child's birth (Alert city/county HIV/AIDS Surveillance) <input type="checkbox"/> 9 HIV status unknown			<input type="checkbox"/> 3 Before pregnancy with this child <input type="checkbox"/> 4 During pregnancy with this child <input type="checkbox"/> 5 At the time of delivery <input type="checkbox"/> 6 Before the child's birth, exact period unknown <input type="checkbox"/> 7 After the child's birth <input type="checkbox"/> 8 HIV-infected, unknown when diagnosed		

Date of mother's first positive HIV confirmatory test: Month Year		Mother was counseled about HIV testing during this pregnancy, labor, or delivery:		Yes No Unknown	
		<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9			
Before the diagnosis of HIV/AIDS, this child's biological mother had:			Before the diagnosis of HIV infection/AIDS, this child had:		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Injected nonprescription drugs.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received clotting factor for hemophilia/coagulation disorder..... (Specify disorder): <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) <input type="checkbox"/> 8 Other (specify): _____		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • HETEROSEXUAL relations with: • Intravenous/injection drug user.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transfusion of blood/components (other than clotting factor)..... (other than clotting factor)..... Month Year 		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Bisexual male.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transplant of tissue/organs.....		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Male with hemophilia/coagulation disorder.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Sexual contact with a male.....		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Transfusion recipient with documented HIV infection.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Sexual contact with a female.....		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Transplant recipient with documented HIV infection.....			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Injected nonprescription drugs.....		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Male with AIDS or documented HIV Infection, risk not specified			Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Other (alert state/city NIR coordinator).....		
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Male with perinatally-acquired HIV.....					
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transfusion of blood/blood components (other than clotting factor).....					
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Received transplant of tissue/organs or artificial insemination.....					
Yes No Unknown <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Perinatally-acquired HIV infection, regardless of mother's date of birth					

VI. Provider Information

Physician's name (last, first, MI)	Patient's medical record number	Person completing form	Physician's Telephone Number ()	
Address (number, street)	City	State	ZIP code	

VII. Laboratory Data (Indicate the first positive test.)

1. HIV Antibody tests at initial diagnosis (Record all tests, include earliest positive.):

	Positive	Negative	Indeterminate	Not done	Test Date		
					Month	Day	Year
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		
				Month	Day	Year
HIV culture.....	1	0	9			
HIV culture.....	1	0	9			
HIV antigen test.....	1	0	9			
HIV antigen test.....	1	0	9			

	Positive	Negative	Not done	Test Date		
				Month	Day	Year
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 earliest test.)

Test type*: Version*: Month Day Year

Other (specify type and version): _____

Test result (Record in copies/mL and log₁₀ values.)

Detectable Copies/mL:

Log₁₀:

Greater than: copies/mL

Undetectable Less than: copies/mL

* Test type and version: 11 = NucliSens® HIV-1 QT (Organon-NASBA)
12 = Amplicor HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5
13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0
18 = Other (kit name/manufacturer/version)

4. Immunologic Lab Tests (At or closest to current diagnostic status.)

CD4 count cells/μl Month Day Year

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 Unknown

1 0 9

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

HIV-infected..... Yes No Unknown Date of Documentation Month Day Year

Not HIV-infected..... Yes No Unknown Month Day Year

1 0 9

VIII. Clinical Status (Def. = Definitive diagnosis / Pres. = Presumptive diagnosis)

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

Has this child been diagnosed with pulmonary tuberculosis?*

1 Yes 0 No 9 Unknown

If yes, initial diagnosis: 1 Definitive 2 Presumptive

Date:

*RVCT case number

