

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients < 13 years of age at time of diagnosis.)

Date form completed Month Day Year	Report status 1 New 2 Update	I. Health Department Use Only			
	Report source	Reporting health department	State patient number	City/county patient number	

II. For HIV and AIDS Cases			For Non-AIDS Cases Only		
Soundex code	Date of birth Month Day Year	Gender 1 Male 2 Female	Last four digits of SSN	Lab report number	*Confidential C&T number

III. Demographic Information			IV. Facility of Diagnosis		
Diagnosis status at report 3 Perinatally HIV exposed 4 Confirmed HIV infection (not AIDS) 5 AIDS 6 Seroreverter	Age at Diagnosis Years Months	Current status 1 Dead 2 Alive 9 Unknown	Date of death Month Day Year	Facility name	
Date of last medical evaluation Month Day Year	Date of initial evaluation for HIV infection Month Day Year	State/Territory of death		City	
Was reason for initial HIV evaluation due to clinical signs and symptoms? 1 Yes 0 No 9 Unknown			State/Country		
Race/ethnicity + White (non-Hispanic) + Black (non-Hispanic) + Hispanic + Asian/Pacific Islander + American Indian/Alaska Native + Not specified			Facility type (check one) 01 Physician, HMO 29 Community Health Center 30 Correctional Facility 31 Hospital, inpatient 32 Hospital, outpatient 88 Other (specify): 99 Unknown		
Country of birth 1 U.S. 7 U.S. Territories (including Puerto Rico) 9 Unknown 8 Other (specify):			Facility setting (check one) 1 Public 2 Private 3 Federal 9 Unknown		
Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country:			Residence at diagnosis: City County State/Country ZIP code		

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

• 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
1	0	9

<p>After 1977, this child's biologic mother had:</p> <ul style="list-style-type: none"> • Injected nonprescription drugs Yes No Unknown 1 0 9 • HETEROSEXUAL relations with: <ul style="list-style-type: none"> • Intravenous/injection drug user Yes No Unknown 1 0 9 • Bisexual male Yes No Unknown 1 0 9 • Male with hemophilia/coagulation disorder Yes No Unknown 1 0 9 • Transfusion recipient with documented HIV infection Yes No Unknown 1 0 9 • Transplant recipient with documented HIV infection Yes No Unknown 1 0 9 • Male with AIDS or documented HIV infection, risk not specified Yes No Unknown 1 0 9 • Received transfusion of blood/blood components (other than clotting factor) Yes No Unknown 1 0 9 • Received transplant of tissue/organs or artificial insemination Yes No Unknown 1 0 9 	<p>Before the diagnosis of HIV infection/AIDS, this <i>child</i> had:</p> <ul style="list-style-type: none"> • Received clotting factor for hemophilia/coagulation disorder Yes No Unknown 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) Yes No Unknown 1 0 9 First: Month Year Last: Month Year • Received transplant of tissue/organs Yes No Unknown 1 0 9 • Sexual contact with a male Yes No Unknown 1 0 9 • Sexual contact with a female Yes No Unknown 1 0 9 • Injected nonprescription drugs Yes No Unknown 1 0 9 • Other (alert state/city NIR coordinator) Yes No Unknown 1 0 9
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STATE/LOCAL USE ONLY

VI. -FOR AIDS CASES ONLY- Patient identifier information is not transmitted to CDC.

Patient's name (last, first, MI)	Telephone number ()	Social Security Number	
Address (number, street)	City	County	State ZIP code

VII. Laboratory Data

1. HIV Antibody Tests at Diagnosis (Record all tests, include earliest positive.):

	Positive	Negative	Indeterminate	Not done	Test Date	
					Month	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			Positive	Negative	Not done	Test Date	
				Month	Year					Month	Year
HIV culture	1	0	9			HIV DNA PCR	1	0	9		
HIV culture	1	0	9			HIV DNA PCR	1	0	9		
HIV antigen test	1	0	9			HIV RNA PCR	1	0	9		
HIV antigen test	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.)

Test Type*	Detectable		Copies/ml	Test Date		Test Type*	Detectable		Copies/ml	Test Date	
	Yes	No		Month	Year		Yes	No		Month	Year
	1	0					1	0			

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

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

CD4 count..... , cells/ul Month 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: Yes No Unknown Date of Documentation Month Year

HIV-infected..... 1 0 9

Not HIV-infected 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 <i>Salmonella</i> 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 month duration)	1	NA			<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary	1	2		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 month of age	1	NA			<i>M. tuberculosis</i> , disseminated or extrapulmonary*	1	2		
Cytomegalovirus retinitis (with loss of vision)	1	2			<i>Mycobacterium</i> of other species or unidentified species, disseminated or extrapulmonary	1	2		
HIV encephalopathy	1	NA			<i>Pneumocystis carinii</i> pneumonia	1	2		
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age	1	NA			Progressive multifocal leukoencephalopathy	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA			Toxoplasmosis of brain, onset at >1 month of age	1	2		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA			Wasting syndrome due to HIV	1	NA		

Has this child been diagnosed with pulmonary tuberculosis?* If yes, initial diagnosis: Month Year *RVCT case number

1 Yes 0 No 9 Unknown 1 Definitive 2 Presumptive Date:

IX. Provider Information

Physician's name (last, first, MI) Telephone number Patient's medical record number Person completing form Telephone number

Address (number, street) City State ZIP code

MAIL COMPLETED FORM TO YOUR LOCAL HEALTH DEPARTMENT.

