

## PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

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

Date form completed Month Day Year	Report status <input type="checkbox"/> 1 New <input type="checkbox"/> 2 Update	<b>I. Health Department Use Only</b>			
	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 <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	Last four digits of SSN	Lab report number	*Confidential C&T number

\*Publicly funded confidential counseling and testing sites only

III. Demographic Information			IV. Facility of Diagnosis		
Diagnosis status at report	Age at Diagnosis Years Months	Current status <input type="checkbox"/> 1 Dead <input type="checkbox"/> 2 Alive <input type="checkbox"/> 9 Unknown	Date of death Month Day Year	Facility name	
<input type="checkbox"/> 3 Perinatally HIV exposed.....			State/Territory of death	City	
<input type="checkbox"/> 4 Confirmed HIV infection (not AIDS)				State/Country	
<input type="checkbox"/> 5 AIDS.....				Facility type (check one)	
<input type="checkbox"/> 6 Seroreverter.....				<input type="checkbox"/> 01 Physician, HMO <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	
Date of last medical evaluation Month Day Year	Date of initial evaluation for HIV infection Month Day Year		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		
Race/ethnicity <input type="checkbox"/> 1 White (non-Hispanic) <input type="checkbox"/> 2 Black (non-Hispanic) <input type="checkbox"/> 3 Hispanic <input type="checkbox"/> 4 Asian/Pacific Islander <input type="checkbox"/> 5 American Indian/Alaska Native <input type="checkbox"/> 9 Not specified			Country of birth <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Territories (including Puerto Rico) <input type="checkbox"/> 9 Unknown <input type="checkbox"/> 8 Other (specify): _____		
<input type="checkbox"/> Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country: _____			Facility setting (check one) <input type="checkbox"/> 1 Public <input type="checkbox"/> 2 Private <input type="checkbox"/> 3 Federal <input type="checkbox"/> 9 Unknown		
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

After 1977, this child's biologic <b>mother</b> had:	Before the diagnosis of HIV infection/AIDS, this <b>child</b> had:
<ul style="list-style-type: none"> <li>• Injected nonprescription drugs..... Yes No Unknown 1 0 9</li> <li>• <b>HETEROSEXUAL</b> relations with:                             <ul style="list-style-type: none"> <li>• Intravenous/injection drug user..... Yes No Unknown 1 0 9</li> <li>• Bisexual male..... Yes No Unknown 1 0 9</li> <li>• Male with hemophilia/coagulation disorder..... Yes No Unknown 1 0 9</li> <li>• Transfusion recipient with documented HIV infection..... Yes No Unknown 1 0 9</li> <li>• Transplant recipient with documented HIV infection..... Yes No Unknown 1 0 9</li> <li>• Male with AIDS or documented HIV infection, risk not specified..... Yes No Unknown 1 0 9</li> </ul> </li> <li>• Received transfusion of blood/blood components (other than clotting factor)..... Yes No Unknown 1 0 9</li> <li>• Received transplant of tissue/organs or artificial insemination..... Yes No Unknown 1 0 9</li> </ul>	<ul style="list-style-type: none"> <li>• Received clotting factor for hemophilia/coagulation disorder..... Yes No Unknown 1 0 9 (Specify disorder): <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) <input type="checkbox"/> 8 Other (specify): _____</li> <li>• Received transfusion of blood/blood components (other than clotting factor)..... Yes No Unknown 1 0 9 Month Year Month Year First: Last:</li> <li>• Received transplant of tissue/organs..... Yes No Unknown 1 0 9</li> <li>• Sexual contact with a male..... Yes No Unknown 1 0 9</li> <li>• Sexual contact with a female..... Yes No Unknown 1 0 9</li> <li>• Injected nonprescription drugs..... Yes No Unknown 1 0 9</li> <li>• Other (alert state/city NIR coordinator)..... Yes No Unknown 1 0 9</li> </ul>

**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/ $\mu$ l    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

6. If laboratory tests were not documented, is patient confirmed by a physician as: ..... Yes  No  Unknown  Date of Documentation Month  Year

HIV-infected..... Yes  No  Unknown

Not HIV-infected..... Yes  No  Unknown

## 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)	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?\*

Yes     No     Unknown

If yes, initial diagnosis:

Definitive     Presumptive

Date:

\*RVCT case number

## 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.



