

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			
Month	Day	Year	Report status	Report source	Reporting health department
			<input type="checkbox"/> 1 New <input type="checkbox"/> 2 Update		
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	State/Territory of death
<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)...			Date of initial evaluation for HIV infection Month Day Year		
<input type="checkbox"/> 5 AIDS.....			Date of last medical evaluation Month Day Year		
<input type="checkbox"/> 6 Seroreverter.....			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		
ETHNICITY		RACE		COUNTRY OF BIRTH	
<input type="checkbox"/> 1 Hispanic		<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> 1 U.S.	<input type="checkbox"/> 9 Unknown
<input type="checkbox"/> 2 Not Hispanic nor Latino		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> 7 U.S. Territories (including Puerto Rico)	
		<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown	<input type="checkbox"/> 8 Other (specify):	
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		
Facility name		State/Country
Facility setting (check one)	Facility type (check one)	
<input type="checkbox"/> 1 Public <input type="checkbox"/> 3 Federal	<input type="checkbox"/> 01 Physician, HMO	<input type="checkbox"/> 29 Community Health Center <input type="checkbox"/> 31 Hospital, inpatient <input type="checkbox"/> 88 Other (specify):
<input type="checkbox"/> 2 Private <input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 22 Counseling and Testing Site <input type="checkbox"/> 30 Correctional Facility	<input type="checkbox"/> 32 Hospital, outpatient <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:		
<input type="checkbox"/> 1 Refused HIV testing	HIV positive or AIDS diagnosis:	
<input type="checkbox"/> 2 Known to be uninfected after this child's birth (Alert city/county HIV/AIDS Surveillance)	<input type="checkbox"/> 3 Before pregnancy with this child	<input type="checkbox"/> 6 Before the child's birth, exact period unknown
<input type="checkbox"/> 9 HIV status unknown	<input type="checkbox"/> 4 During pregnancy with this child	<input type="checkbox"/> 7 After the child's birth
	<input type="checkbox"/> 5 At the time of delivery	<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:	
• Injected nonprescription drugs.....	Yes No Unknown	• Received clotting factor for hemophilia/coagulation disorder.....	Yes No Unknown
<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	
• HETEROSEXUAL relations with:	Yes No Unknown	(Specify disorder): <input type="checkbox"/> 1 Factor VIII (Hemophilia A)	
• Intravenous/injection drug user.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	<input type="checkbox"/> 2 Factor IX (Hemophilia B) <input type="checkbox"/> 8 Other (specify):	
• Bisexual male.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	• Received transfusion of blood/components (other than clotting factor).....	Yes No Unknown
• Male with hemophilia/coagulation disorder.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	<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	First: Month Year Last: Month Year	
• Transplant recipient with documented HIV infection.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		Yes No Unknown
• Male with AIDS or documented HIV Infection, risk not specified	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	• Received transplant of tissue/organs.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9
• Male with perinatally-acquired HIV.....	<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
• Received transfusion of blood/blood components (other than clotting factor).....	Yes No Unknown	• Sexual contact with a female.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9
<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
• Received transplant of tissue/organs or artificial insemination.....	<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
• Perinatally-acquired HIV infection, regardless of mother's date of birth	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		

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: Yes No Unknown Date of Documentation
 HIV-infected..... 1 0 9 Month Day Year
 Not HIV-infected..... 1 0 9 Month Day Year

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

Has this child been diagnosed with pulmonary tuberculosis? * Yes No Unknown If yes, initial diagnosis: Definitive Presumptive Date: Month Year *RVCT case number

IX. Birth History (For PERINATAL cases only.)

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

Hospital at birth:	Name of hospital	Address (number, street)	City	County	State	ZIP code	Country
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Residence at birth:	City	County	State	ZIP code	Country
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Birth weight (enter lbs/oz or grams) [] lbs. [] oz. [] grams	Birth Type: <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Twin <input type="checkbox"/> 3 >2 <input type="checkbox"/> 9 Unknown	Neonatal status: (99 = Unknown)	Prenatal Care (99 = Unknown/00 = None)
	Delivery: <input type="checkbox"/> 1 Vaginal <input type="checkbox"/> 2 Elective Caesarean <input type="checkbox"/> 3 Nonelective Caesarean <input type="checkbox"/> 4 Caesarean, unknown type <input type="checkbox"/> 9 Unknown	<input type="checkbox"/> 1 Full term <input type="checkbox"/> 2 Premature	Month of pregnancy prenatal care began: [] Months
Birth defects: <input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown Specify type(s): _____ Code: [] [] [] [] [] [] [] [] [] []	[] weeks		

Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused Yes No Unknown
[] 8 [] 1 [] 0 [] 9

If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? (99 = Unknown) [] weeks

Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Refused Yes No Unknown
[] 8 [] 1 [] 0 [] 9

Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes No Unknown
[] 1 [] 0 [] 9

Did mother receive any other anti-retroviral during pregnancy? Yes No Unknown
[] 1 [] 0 [] 9

If yes, specify: _____

Did mother receive any other anti-retroviral medication during labor/delivery? Yes No Unknown
[] 1 [] 0 [] 9

If yes, specify: _____

Biological Mother's date of birth Month Day Year [] [] []	Biological Mother's Soundex [] [] [] []	Biological Mother's State Patient Number [] [] [] [] [] [] [] [] [] []
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Birthplace of biological mother
 1 U.S. 7 U.S. Territories (including Puerto Rico) (specify): _____
 8 Other (specify): _____ 9 Unknown

X. Treatment/Services Referrals

This child received or is receiving:	DATE STARTED	DATE STARTED
Neonatal zidovudine (ZDV, AZT) for HIV prevention	Yes No Unknown Month Day Year [] 1 [] 0 [] 9 [] [] [] [] [] []	Anti-retroviral therapy for HIV treatment
Other neonatal anti-retroviral medication for HIV prevention	Yes No Unknown Month Day Year [] 1 [] 0 [] 9 [] [] [] [] [] []	PCP prophylaxis
If yes, specify: _____		

Was child breastfed? Yes No Unknown [] 1 [] 0 [] 9	This child has been enrolled at: <i>Clinical trial</i> [] 1 NIH-sponsored [] 2 Other [] 3 None [] 9 Unknown <i>Clinic</i> [] 1 HRSA-sponsored [] 2 Other [] 3 None [] 9 Unknown	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 Unknown
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This child's primary caretaker is:
 1 Biological 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 Unknown

XI. Comments

MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
 LHD contact information is available on the website: www.dhs.ca.gov/AIDS

