

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		State patient number
			<input type="checkbox"/> 2 Update		City/county patient number
Soundex code	Date of birth (mm/dd/yyyy)		Gender	CLIA number	Lab report/Accession number
	Month	Day	Year	<input type="checkbox"/> 1 Male	
				<input type="checkbox"/> 2 Female	
					*Confidential C&T number
					<input type="text"/>

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"/> 4 Confirmed HIV infection (not AIDS)...			<input type="checkbox"/> 2 Dead		Date of initial evaluation for HIV infection Month Day Year
<input type="checkbox"/> 5 AIDS.....			<input type="checkbox"/> 9 Unknown		
<input type="checkbox"/> 6 Seroreverter.....			Was reason for initial HIV evaluation due to clinical signs and symptoms?		Date of last medical evaluation Month Day Year
				<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown	
ETHNICITY		RACE		COUNTRY OF BIRTH	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Not Hispanic nor Latino	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> White
		<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown	<input type="checkbox"/> 1 U.S.	<input type="checkbox"/> 9 Unknown
Expanded race (specify):				<input type="checkbox"/> 7 U.S. Territories (including Puerto Rico)	<input type="checkbox"/> 8 Other (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"/> 3 Federal	<input type="checkbox"/> 01 Physician, HMO	<input type="checkbox"/> 29 Community Health Center	<input type="checkbox"/> 31 Hospital, inpatient
<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"/> 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"/> 3 Before pregnancy with this child
<input type="checkbox"/> 2 Known to be uninfected after this child's birth (Alert city/county HIV/AIDS Surveillance)	<input type="checkbox"/> 4 During pregnancy with this child
<input type="checkbox"/> 9 HIV status unknown	<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:	
• 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		
• Male with hemophilia/coagulation disorder.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	• Received transfusion of blood/components (other than clotting factor).....	Yes No Unknown
• Transfusion recipient with documented HIV infection.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9
• Transplant recipient with documented HIV infection.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	First: Month Year	Last: Month Year
• Male with AIDS or documented HIV Infection, risk not specified	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		Yes No Unknown
• Male with perinatally-acquired HIV.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9		<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	• Received transplant of tissue/organs.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9
	<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 transplant of tissue/organs or artificial insemination.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	• Sexual contact with a female.....	<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	• Injected nonprescription drugs.....	<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

VI. Provider Information

Physician's name (last, first, MI)	Patient's medical record number	Person completing form	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				Positive	Negative	Not done	Test Date		
				Month	Day	Year					Month	Day	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 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 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 checked="" type="checkbox"/>	NA			Kaposi's sarcoma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Candidiasis, bronchi, trachea, or lungs	<input checked="" type="checkbox"/>	NA			Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Candidiasis, esophageal	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			Lymphoma, Burkitt's (or equivalent term)	<input checked="" type="checkbox"/>	NA		
Coccidioidomycosis, disseminated or extrapulmonary	<input checked="" type="checkbox"/>	NA			Lymphoma, immunoblastic (or equivalent term)	<input checked="" type="checkbox"/>	NA		
Cryptococcosis, extrapulmonary	<input checked="" type="checkbox"/>	NA			Lymphoma, primary in brain	<input checked="" type="checkbox"/>	NA		
Cryptosporidiosis, chronic intestinal (>1 month duration)	<input checked="" type="checkbox"/>	NA			Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 month of age	<input checked="" type="checkbox"/>	NA			M. tuberculosis, disseminated or extrapulmonary*	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Cytomegalovirus retinitis (with loss of vision)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
HIV encephalopathy	<input checked="" type="checkbox"/>	NA			Pneumocystis jiroveci pneumonia (PCP)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age	<input checked="" type="checkbox"/>	NA			Progressive multifocal leukoencephalopathy	<input checked="" type="checkbox"/>	NA		
Histoplasmosis, disseminated or extrapulmonary	<input checked="" type="checkbox"/>	NA			Toxoplasmosis of brain, onset at >1 month of age	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Isosporiasis, chronic intestinal (>1 month duration)	<input checked="" type="checkbox"/>	NA			Wasting syndrome due to HIV	<input checked="" type="checkbox"/>	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) <input type="text"/> lbs. <input type="text"/> oz. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> grams	Birth Type: <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Twin <input type="checkbox"/> 3 >2 <input type="checkbox"/> 9 Unknown Delivery: <input type="checkbox"/> 1 Vaginal <input type="checkbox"/> 2 Elective Caesarean <input type="checkbox"/> 3 Nonelective Caesarean <input type="checkbox"/> 9 Unknown <input type="checkbox"/> 4 Caesarean, unknown type Birth defects: <input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown Specify type(s): _____ Code: <input type="text"/> <input type="text"/> <input type="text"/>	Neonatal status: (99 = Unknown) <input type="checkbox"/> 1 Full term <input type="checkbox"/> 2 Premature <input type="text"/> <input type="text"/> weeks	Prenatal Care (99 = Unknown/00 = None) Month of pregnancy prenatal care began: <input type="text"/> <input type="text"/> Months Total number of prenatal care visits: <input type="text"/> <input type="text"/>
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Did mother receive zidovudine (ZDV, AZT) during pregnancy?..... If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? (99 = Unknown)..... <input type="text"/> weeks Did mother receive zidovudine (ZDV, AZT) during labor/delivery?..... Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?.....	Refused Yes No Unknown 8 1 0 9 8 1 0 9 1 0 9	Did mother receive any other anti-retroviral during pregnancy?..... If yes, specify: _____ Did mother receive any other anti-retroviral medication during labor/delivery?..... If yes, specify: _____	Yes No Unknown 1 0 9 1 0 9
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Biological Mother's date of birth Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>	Biological Mother's Soundex <input type="text"/> <input type="text"/> <input type="text"/>	Biological Mother's State Patient Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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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: Neonatal zidovudine (ZDV, AZT) for HIV prevention..... Other neonatal anti-retroviral medication for HIV prevention..... If yes, specify: _____	Yes No Unknown 1 0 9 1 0 9	DATE STARTED Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>	Anti-retroviral therapy for HIV treatment..... PCP prophylaxis.....	Yes No Unknown 1 0 9 1 0 9	DATE STARTED Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>
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Was child breastfed? Yes No Unknown 1 0 9	This child has been enrolled at: <i>Clinical trial</i> <input type="checkbox"/> 1 NIH-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unknown <i>Clinic</i> <input type="checkbox"/> 1 HRSA-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unknown	This child's medical treatment is primarily reimbursed by <input type="checkbox"/> 1 Medicaid <input type="checkbox"/> 2 Private insurance/HMO <input type="checkbox"/> 3 No coverage <input type="checkbox"/> 4 Other public funding <input type="checkbox"/> 7 Clinical trial/government program <input type="checkbox"/> 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

