I STATE/LOCAL USE ONLY

Patient's Name: _____ (Last, First, M.I.) Phone No.: ( ) _____

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT — *Patient identifier information is not transmitted to CDC!* —

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

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

CDC

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0009

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

SOUNDEX CODE:

REPORT STATUS: 1 New Report 2 Update

REPORTING HEALTH DEPARTMENT: State: City/County:

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) 3 Perinatally HIV Exposed 4 Confirmed HIV Infection (not AIDS) 5 AIDS 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months — HIV Infection (not AIDS) ... AIDS ...

CURRENT STATUS: 1 Alive 2 Dead 9 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes 1 No 0 Unk. 9

SEX: 1 Male 2 Female

RACE/ETHNICITY: 1 White (not Hispanic) 2 Black (not Hispanic) 3 Hispanic 4 Asian/Pacific Islander 5 American Indian/Alaska Native 9 Not specified

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/Country: _____

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 88 Other (specify): _____

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: ..... Mo. Yr.

• Mother was counseled about HIV testing during this pregnancy, labor or delivery? ..... Yes 1 No 0 Unk 9

After 1977, this child's biologic mother had:

	Yes	No	Unk.
• Injected nonprescription drugs	1	0	9
• *HETEROSEXUAL* relations with:			
- Intravenous/injection drug user	1	0	9
- Bisexual male	1	0	9
- Male with hemophilia/coagulation disorder	1	0	9
- Transfusion recipient with documented HIV infection	1	0	9
- Transplant recipient with documented HIV infection	1	0	9
- Male with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9

Before the diagnosis of HIV Infection/AIDS, this child had:

	Yes	No	Unk
• Received clotting factor for hemophilia/coagulation disorder	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)	1	0	9
First: Mo. Yr. Last: Mo. Yr.			
• Received transplant of tissue/organs	1	0	9
• Sexual contact with a male	1	0	9
• Sexual contact with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• Other (Alert State/City NIR Coordinator)	1	0	9

IX. BIRTH HISTORY (for PERINATAL cases only)

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

HOSPITAL AT BIRTH:

Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/ Country: _____ Zip Code: [ ][ ][ ][ ][ ] [ ][ ][ ][ ]

BIRTHWEIGHT: (enter lbs/oz OR grams)

[ ][ ] lbs. [ ][ ] oz

[ ][ ][ ][ ] grams

BIRTH:

TYPE: ..... [1] Single [2] Twin [3] >2 [9] Unk.

DELIVERY: ..... [1] Vaginal [2] Caesarean [9] Unk.

BIRTH DEFECTS: ..... [1] Yes [0] No [9] Unk.

Specify type(s): _____ Code: [ ][ ][ ] [ ][ ][ ]

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks: [ ][ ] 99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: [ ][ ] 99 = Unk. mos.

Total number of prenatal care visits: [ ][ ] 99 = Unk.

- Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused [8] Yes [1] No [0] Unk. [9]
- If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: [ ][ ] 99 = Unk.
- Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Refused [8] Yes [1] No [0] Unk. [9]
- Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes [1] No [0] Unk. [9]
- Did mother receive any other Anti-retroviral medication during pregnancy? Yes [1] No [0] Unk. [9]

If yes, specify: _____

Maternal Date of Birth Mo. Day Yr. [ ][ ] [ ][ ] [ ][ ]

Maternal Soundex: [ ][ ][ ][ ]

Maternal State Patient No. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Birthplace of Biologic Mother:

[1] [illegible] [7] U.S. Dependencies and Possessions (including Puerto Rico)

[8] Other (specify) _____ [9]

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo.	Day	Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV prevention	[1]	[0]	[9]	[ ][ ]	[ ][ ]	[ ][ ]
• Anti-retroviral therapy for HIV treatment	[1]	[0]	[9]	[ ][ ]	[ ][ ]	[ ][ ]
• PCP prophylaxis	[1]	[0]	[9]	[ ][ ]	[ ][ ]	[ ][ ]
• IVIG therapy	[1]	[0]	[9]			

Was child breastfed? Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial

[1] NIH-sponsored [2] Other

[3] None [9] Unk.

Clinic

[1] HRSA-sponsored [2] Other

[3] None [9] Unk.

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] Unk.

This child's primary caretaker is:

[1] Biologic 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] Unk.

XI. COMMENTS:

_____

_____

_____

_____

_____

_____

(XI. COMMENTS CONTINUED ON THE BACK)

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in the surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 306(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0009); Rm 531 H, H.H. Humphrey Bg.; 200 Independence Ave., SW, Washington, DC 20201. – DO NOT MAIL CASE REPORT FORMS TO THESE ADDRESSES –

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• 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		
• HIV–2 EIA	1	0	–	9		
• HIV–2 Western blot	1	0	8	9		

2. HIV DETECTION TESTS:
(Record all tests, include earliest positive)

	Pos.	Neg.	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• HIV PCR, DNA or RNA probe	1	0	9		
• HIV PCR, DNA or RNA probe	1	0	9		
• Other (specify): _____	1	0	9		

3. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

			Mo.	Yr.
• CD4 Count	___,___	cells/µL		
• CD4 Count	___,___	cells/µL		
• CD4 Percent	___	%		
• CD4 Percent	___	%		

4. 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 1 No 0 Unk. 9

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

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Seroreverter	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. Mo. Yr.

If yes, initial diagnosis and date: 1 Definitive 2 Presumptive

*RVCT CASE NO.:

XI. COMMENTS (continued)