Reset Patient Identification

Reset Form

Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex

Alternate Name Type (example: Birth, Call Me)	*First Name	*Middle Name	*Last Name

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street	Address Date
		__ __ /__ __ /__ __ __ __

*Phone ( )	City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type	*Number

U.S. Department of Health and Human Services

Pediatric HIV Confidential Case Report Form

(Patients aged <13 years at time of diagnosis) *Information NOT transmitted to CDC

Centers for Disease Control and Prevention (CDC)

Health Department Use Only (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 11/30/2022

Date Received at Health Department __ __ /__ __ /__ __ __ __	eHARS Document UID	State Number

Reporting Health Dept—City/County	City/County Number

Document Source	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown

Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 6-CD/disk

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name	*Phone ( )

*Street Address

City	County	State/Country	*ZIP Code

Facility Type — *Inpatient:* ☐ Hospital ☐ Other, specify_____ *Outpatient:* ☐ Private physician's office ☐ Pediatric clinic ☐ Pediatric HIV clinic ☐ Other, specify_____ *Other Facility:* ☐ Emergency room ☐ Laboratory ☐ Unknown ☐ Other, specify _____

Date Form Completed __ __ /__ __ /__ __ __ __	*Person Completing Form	*Phone ( )

Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report ☐ 3-Perinatal HIV exposure ☐ 4-Pediatric HIV ☐ 5-Pediatric AIDS ☐ 6-Pediatric seroreverter	Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US dependency (please specify) _____

Date of Birth __ __ /__ __ /__ __ __ __	Alias Date of Birth __ __ /__ __ /__ __ __ __

Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __ /__ __ /__ __ __ __	State of Death

Date of Last Medical Evaluation __ __ /__ __ /__ __ __ __	Date of Initial Evaluation for HIV __ __ /__ __ /__ __ __ __

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity

Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Go To Comments

Address Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Residence at perinatal exposure ☐ Residence at pediatric seroreverter ☐ Check if SAME as current address

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

*Street Address

City	County	State/Country	*ZIP Code

This report to CDC 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. Information in CDC's National HIV 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 308(d) of the Public Health Service Act (42 USC 242m).

Save Form Next Page

Previous Page

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.) *Phone ( )

Hospital/Facility

Facility of Diagnosis (add additional facilities in Comments)

Go To Comments

Diagnosis Type (check all that apply to facility below) ☐HIV ☐Stage 3 (AIDS) ☐Perinatal exposure ☐Check if SAME as facility providing information

Facility Name			***Phone** ( )
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**

Facility Type *Inpatient*: ☐Hospital ☐Other, specify _____ *Outpatient*: ☐Private physician's office ☐Pediatric clinic ☐Pediatric HIV clinic ☐Other, specify _____ *Other Facility*: ☐Emergency room ☐Laboratory ☐Unknown ☐Other, specify _____

***Provider Name**	***Provider Phone** ( )	**Specialty**

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Child's biological mother's HIV infection status (select one): ☐Refused HIV testing ☐Known to be uninfected after this child's birth ☐Known HIV+ before pregnancy ☐Known HIV+ during pregnancy ☐Known HIV+ sometime before birth ☐Known HIV+ at delivery ☐Known HIV+ after child's birth ☐HIV+, time of diagnosis unknown ☐HIV status unknown

Date of mother's first positive test to confirm infection __ __ /__ __ /__ __ __ __	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? ☐Yes ☐No ☐Unknown

After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV infection	☐Yes ☐No ☐Unknown
Injected nonprescription drugs	☐Yes ☐No ☐Unknown
Biological mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐Yes ☐No ☐Unknown
HETEROSEXUAL contact with bisexual male	☐Yes ☐No ☐Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐Yes ☐No ☐Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐Yes ☐No ☐Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐Yes ☐No ☐Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐Yes ☐No ☐Unknown
Biological mother had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __	☐Yes ☐No ☐Unknown
Received transplant of tissue/organs or artificial insemination	☐Yes ☐No ☐Unknown
Before the diagnosis of HIV infection, this child had:	
Injected nonprescription drugs	☐Yes ☐No ☐Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received __ __ /__ __ /__ __ __ __	☐Yes ☐No ☐Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __	☐Yes ☐No ☐Unknown
Received transplant of tissue/organs	☐Yes ☐No ☐Unknown
Sexual contact with male	☐Yes ☐No ☐Unknown
Sexual contact with female	☐Yes ☐No ☐Unknown
Other documented risk (please include detail in Comments)	☐Yes ☐No ☐Unknown

Clinical: Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

Save Form Next Page

Previous Page

Go To Comments

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay** (differentiates between HIV-1 Ab and HIV-2 Ab)

Role of test in diagnostic algorithm ☐ Screening/initial test ☐ Confirmatory/supplemental test

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative

Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

[1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid

Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive **Index value** _____

Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____

HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____

HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____

Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

[2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) **Note: Include earliest test at or after diagnosis.**

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Collection Date __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

First CD4 result <200 cells/μL or <14%: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown

If YES, provide specimen collection date of earliest positive test for this algorithm __ __ /__ __ /__ __ __ __

*Complete the above only if none of the following were positive for **HIV-1**: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

If laboratory tests were not documented, is patient confirmed by a physician as **HIV-infected** ☐ Yes ☐ No ☐ Unknown **Date of diagnosis** __ __ /__ __ /__ __ __ __

Not HIV-infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis** __ __ /__ __ /__ __ __ __

Save Form Next Page

Previous Page

Birth History (for Perinatal Cases only)

Birth history available? ☐ Yes ☐ No ☐ Unknown

Residence at Birth ☐ Check if SAME as current address

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

***Street Address** | **City**

County | **State/Country** | ***ZIP Code**

Facility of Birth ☐ Check if SAME as facility providing information

Facility Name of Birth
(if child was born at home, enter "home birth")

***Phone**
( )

Facility Type *Inpatient*: ☐ Hospital ☐ Other, specify_____ *Outpatient:* ☐ Other, specify_____ *Other Facility*: ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify_____

***Street Address** | **City**

County | **State/Country** | ***ZIP Code**

Birth History | **Birth Weight** _____lbs _____oz _____grams | **Type** ☐ 1-Single ☐ 2-Twin ☐ 3-More than two ☐ 9-Unknown

Delivery ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Nonelective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown

Birth Defects ☐ Yes ☐ No ☐ Unknown **If yes, specify types**

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ 9-Unknown | **Neonatal Gestational Age in Weeks** (99 = Unknown, 00 = None)

Prenatal Care—Month of Pregnancy Prenatal Care Began
(99 = Unknown, 00 = None)

Prenatal Care—Total Number of Prenatal Care Visits
(99 = Unknown, 00 = None)

Did mother receive any antiretrovirals (ARVs) prior to this pregnancy?
☐ Yes ☐ No ☐ Refused ☐ Unknown
Date began __ __/__ __/__ __ __ __ **Date of last use** __ __/__ __/__ __ __ __
If yes, specify all ARVs

Did mother receive any ARVs during pregnancy?
☐ Yes ☐ No ☐ Refused ☐ Unknown
Date began __ __/__ __/__ __ __ __ **Date of last use** __ __/__ __/__ __ __ __
If yes, specify all ARVs

Did mother receive any ARVs during labor/delivery?
☐ Yes ☐ No ☐ Refused ☐ Unknown
Date began __ __/__ __/__ __ __ __ **Date of last use** __ __/__ __/__ __ __ __
If yes, specify all ARVs

Maternal Information | **Maternal DOB** __ __/__ __/__ __ __ __ | **Maternal Last Name Soundex**

Maternal State ID Number | **Maternal Country of Birth**

***Other Maternal ID (specify type of ID and ID number)**

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

This child ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

☐ PrEP ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

☐ PEP ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

☐ PMTCT ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

☐ HBV Tx ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

☐ Other (specify reason)_____

ARV medications _____ Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

Has this child ever taken PCP prophylaxis ☐ Yes ☐ No ☐ Unknown Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __

Was this child breastfed? ☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is ☐ 1-Biological parent ☐ 2-Other relative ☐ 3-Foster/Adoptive parent, relative ☐ 4-Foster/Adoptive parent, unrelated ☐ 7-Social service agency ☐ 8-Other (please specify in comments) ☐ 9-Unknown

Comments

Return

*Local/Optional Fields

Print Form Save Form