Reset Form

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

Reset Patient Identification

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Birth, Call Me)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ 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 & Human Services

Pediatric HIV Confidential Case Report Form

(Patients <13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control and Prevention

Form approved OMB no. 0920-0573 Exp. 06/30/2019

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

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 Type (Check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at AIDS diagnosis ☐ Residence at Perinatal Exposure ☐ Residence at Pediatric Seroreverter ☐ Check if SAME as Current Address			
* Street Address			Address Date __ __/__ __/__ __ __ __
City	County	State/Country	*ZIP Code

Public reporting burden of this collection of information is estimated to average 20 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 CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: (PRA (0920-0573). **Do not send the completed form to this address.**

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STATE/LOCAL USE ONLY

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

_____ *Phone ( ) _____

Hospital/Facility _____

Facility of Diagnosis (add additional facilities in Comments)

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Diagnosis Type (Check all that apply to facility below) ☐ HIV ☐ 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 HIV confirmatory test: __ __ / __ __ / __ __ __ __	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 non-prescription 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
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 non-prescription 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

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

HIV Immunoassays (Non-differentiating)

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: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

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: _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer: _____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer: _____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)
Test Brand Name/Manufacturer: _____

RESULT*: HIV-1 Ag
☐ Reactive ☐ Nonreactive ☐ Not Reported
Collection Date: __ __ /__ __ /__ __ __ __

HIV-Ab
☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV Ab

HIV Detection Tests (Qualitative)

TEST: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ 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)

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)

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

Immunologic Tests (CD4 count and percentage)

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

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

Other CD4 result: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

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 was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

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:** __ __ /__ __ /__ __ __ __

Clinical (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†	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary†	
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 hyperplasia		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	

†If TB selected above, indicate RVCT Case Number:

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Birth History (for Perinatal Cases only)

Residence at Birth

Birth History Available ☐ Yes ☐ No ☐ Unknown ☐ Check if SAME as Current Address

*** 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 ( )** _____ | ***ZIP Code**

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Other, specify _____ *Other Facility:* ☐ Emergency Room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address** | **City** | **County** | **State/Country**

Birth History

Birth Weight _____ lbs _____ oz _____ grams

Type ☐ 1-Single ☐ 2-Twin ☐ 3->2 ☐ 9-Unknown

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

Birth Defects ☐ Yes ☐ No ☐ Unknown | **If yes, please specify:**

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ Unknown | **Neonatal Gestational Age in Weeks:** _____ (99–Unknown)

Gestational Month Prenatal Care Began _____ (00-None, 99-Unknown) | **Prenatal Care – Total number of prenatal care visits:** _____ (00-None, 99-Unknown)

Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Maternal Information

Maternal DOB | **Maternal Last Name Soundex** | **Maternal Stateno** | **Maternal Country of Birth**

***Other Maternal ID – List Type** | **Number**

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

This child received or is receiving:

Neonatal ARVs for HIV prevention: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

If Yes, please specify: 1) 2) 3) 4) 5)

Anti-retroviral therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

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

Mail completed forms in envelope marked "Confidential" to: Ohio Department of Health, HIV Surveillance Program, 246 North High Street, Columbus, Ohio 43216-0118

This report to the Centers for Disease Control and Prevention (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).

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