



Pediatric HIV/AIDS Confidential Case Report

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

I. HEALTH DEPT USE ONLY

Date rec'd at Health Dept. (mm/dd/yyyy format)

Document Source	New Investigation yes no	Report Medium FV M F Ph ET DK	Surveillance Method A F P R	State Number
A _____				
Report Status New Update	Rptg. CHD City	Date form completed: / /		

II. PATIENT NAME

Patient Name (Last, First, MI)	SS#: - -
Address	City County
State Zip	Phone () City/County Patient Number

III. DEMOGRAPHIC INFORMATION

Diagnostic Status <input type="checkbox"/> Perinatal HIV Exposure <input type="checkbox"/> Pediatric HIV <input type="checkbox"/> Pediatric AIDS <input type="checkbox"/> Pediatric Seroreverter	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Date of Birth ____/____/____	Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Date of Death Date: ____/____/____ State/Terr of Death:	Country of Birth <input type="checkbox"/> U.S. <input type="checkbox"/> U.S. Minor Outlying Area <input type="checkbox"/> Other <input type="checkbox"/> Unknown If Other or U.S. Minor Outlying Area, specify:
Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/AA <input type="checkbox"/> White <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unknown					
Residence at Diagnosis: <input type="checkbox"/> Same as Current Street Address: _____ City: _____ County: _____ State/Country: _____ Zip: _____					

IV. FACILITY AND PROVIDER OF DIAGNOSIS / PERINATAL EXPOSURE / FACILITY OF CARE

Facility Name:	Facility Setting (check one) <input type="checkbox"/> Public <input type="checkbox"/> Federal <input type="checkbox"/> Private <input type="checkbox"/> Other	Provider Name (Last, First, MI)
Address:	Facility Type (check one) <input type="checkbox"/> Inpatient Facility <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Other	Provider Ph. No. ()
City:	Facility Code:	Med. Rec. No:
State/Country: Zip:		Person Completing Form (Last, First, MI)
		Phone No. ()

V. PATIENT / MATERNAL HISTORY

Child's biological mother's HIV infection status: <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> HIV status unknown <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ at time of delivery <input type="checkbox"/> Known HIV+ after the child's birth <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> HIV+, time of diagnosis unknown			
Date of mother's first positive HIV confirmatory test (mm/dd/yyyy): / /	Was the biological mother counseled about HIV testing during this pregnancy, labor or delivery? (circle one) Yes No Unknown		
Preceding the first positive HIV antibody test or AIDS diagnosis, the child's biological mother had (respond to all categories)			Yes No Unk
Perinatally acquired HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injected non-prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HETEROSEXUAL relations with any of the following:			
Intravenous/injection drug user	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male with hemophilia/coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion recipient with documented HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplant recipient with documented HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received transfusion of blood/blood components (other than clotting factor) (document reason in the comments section)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First date received: _____	Last date received: _____		
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preceding the first positive antibody test or AIDS diagnosis, this child had (respond to all categories)			Yes No Unk
Injected non-prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify Clotting _____	Date received (mm/dd/yyyy): _____		
Received transfusion of blood/blood components (other than clotting factor) (document in the Comments section)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First date received: _____	Last date received: _____		
Received transplant of tissue/organs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual contact with male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is pediatric sexual contact being investigated or considered as primary mode of exposure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual contact with female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is pediatric sexual contact being investigated or considered as primary mode of exposure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other documented risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is other exposure being investigated or considered as primary mode of exposure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IX. TREATMENT/SERVICES REFERRALS

This child received or is receiving:		Date Started (mm/dd/yy)
Neonatal zidovudine (ZDV, AZT) for HIV prevention	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other neonatal anti-retroviral medication for HIV prevention	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If Yes , specify the medications:		
Anti-retroviral therapy for HIV treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PCP prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was the child breastfed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
This patient has been enrolled at (clinical trial)	<input type="checkbox"/> 1-NIH sponsored <input type="checkbox"/> 2-Other <input type="checkbox"/> 3-None <input type="checkbox"/> 9-Unknown	
This patient has been enrolled at (clinic)	<input type="checkbox"/> 1-NIH sponsored <input type="checkbox"/> 2-Other <input type="checkbox"/> 3-None <input type="checkbox"/> 9-Unknown	
At the time of HIV/AIDS diagnosis, medical treatment is primarily reimbursed by:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Pvt. Ins/HMO <input type="checkbox"/> Other: _____	
This child's primary caretaker is:	<input type="checkbox"/> Biological parents <input type="checkbox"/> Foster/adoptive parent, relative <input type="checkbox"/> Social service agency <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Other relative <input type="checkbox"/> Foster/adoptive parent, unrelated <input type="checkbox"/> Other (if Other , please specify):	

VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test - mm/dd/yyyy)			HIV Detection Tests: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 IFA			HIV-1 P24 Antigen		
HIV-1 Western Blot			HIV-1RNA PCR (Qual)		
HIV-1 EIA			HIV-1 Culture		
HIV-1/2 EIA			HIV-1 Proviral DNA (Qual)		
Other			HIV-2 Culture		
HIV-2 EIA			Other		
Viral Load Test: (<u>most recent</u> test- mm/dd/yyyy)			Immunologic Lab Test: (test date-mm/dd/yyyy)		
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date	
HIV-1 RNA NASBA			CD4 Count: _____ cells/ul (_____ %)		
HIV-1 RNA RT-PCR			First <200 or <14% of total lymphocytes		
HIV-1 RNA bDNA			CD4 Count: _____ cells/ul (_____ %)		
HIV-1 RNA Other					
Was patient confirmed by a physician as:					
HIV- infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes , enter date of diagnosis (mm/dd/yyyy)		
Not HIV- infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes , enter date of diagnosis (mm/dd/yyyy)		

VII. CLINICAL STATUS

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date		Def.	Pres.		Initial DxDate		Def.	Pres.
	mm/dd/yy					mm/dd/yy			
Bacterial infection, multiple or recurrent (including Salmonella septicemia)	___/___/___		<input type="checkbox"/>		Kaposi's sarcoma	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, bronchi, trachea, or lungs	___/___/___		<input type="checkbox"/>		Lymphoid interstitial pneumonia and/or pulmonary lymphoid	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma, Burkitt's (or equivalent)	___/___/___		<input type="checkbox"/>	
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___		<input type="checkbox"/>		Lymphoma, immunoblastic (or equivalent)	___/___/___		<input type="checkbox"/>	
Cryptococcosis, extrapulmonary	___/___/___		<input type="checkbox"/>		Lymphoma, primary in brain	___/___/___		<input type="checkbox"/>	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	___/___/___		<input type="checkbox"/>		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at > 1 mo of age	___/___/___		<input type="checkbox"/>		M. tuberculosis, disseminated, or extrapulmonary *	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___		<input type="checkbox"/>		Pneumocystis carinii pneumonia	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis onset >1 mo of age	___/___/___		<input type="checkbox"/>		Progressive multifocal leukoencephalopathy	___/___/___		<input type="checkbox"/>	
Histoplasmosis, disseminated, or extrapulmonary	___/___/___		<input type="checkbox"/>		Toxoplasmosis of brain, onset at >1 mo of age	___/___/___		<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal (>1 mo. duration)	___/___/___		<input type="checkbox"/>		Wasting syndrome due to HIV	___/___/___		<input type="checkbox"/>	
Has the child been diagnosed with pulmonary tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
If Yes , initial diagnosis and date <input type="checkbox"/> TB pre- 1993 <input type="checkbox"/> Definitive <input type="checkbox"/> Presumptive <input type="checkbox"/> Unknown (mm/dd/yyyy)									
RVCT Case Number									

