



# Pediatric HIV/AIDS Confidential Case Report

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

## I. HEALTH DEPT USE ONLY

Document Source	New Investigation	Report Medium	Surveillance Method	State Number
A _____	yes no	FV M F Ph ET DK	A F P R U	

Report Status  New  Update Rptg. CHD City/Co: \_\_\_\_\_ Date form completed: / /

## II. PATIENT IDENTIFIER INFORMATION - data not transmitted to CDC (must be filled out completely)

Patient Name \_\_\_\_\_ SS#: - -

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ City/County Patient Number \_\_\_\_\_

## III. DEMOGRAPHIC INFORMATION - complete ALL fields

Diagnostic Status	Sex at Birth	Date of Birth	Status	Date of Death	Country of Birth
<input type="checkbox"/> Perinatal HIV Exposure <input type="checkbox"/> Pediatric HIV <input type="checkbox"/> Pediatric AIDS <input type="checkbox"/> Pediatric Seroreverter	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	____/____/____	<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Date: ____/____/____ State/Terr of Death: _____	<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):  Hispanic  Not Hispanic or Latino  Unknown

Race: (select all that apply)  American Indian or Alaska Native  Asian  Black/AA  White  Hawaiian/PI  Unknown

Residence at Diagnosis:  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 _____
Address: _____	Facility Code: _____	Provider Ph. No. ( ) _____
City: _____		Med. Rec. No: _____
State/Country: _____ Zip: _____		Person Completing Form _____
		Phone No. ( 727 ) _____

## V. PATIENT / MATERNAL HISTORY - complete ALL fields

Child's biological mother's HIV infection status:

Refused HIV testing  Known to be uninfected after this child's birth  HIV status unknown  
 Known HIV+ before pregnancy  Known HIV+ at time of delivery  Known HIV+ after the child's birth  
 Known HIV+ during pregnancy  Known HIV+ sometime before birth  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**

<b>This child received or is receiving:</b>			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 <b>Yes</b> , 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 <b>Other</b> , please specify):		

**VI. LABORATORY DATA**

<b>HIV Antibody Tests at Diagnosis</b> (Indicate first test - mm/dd/yyyy)			<b>HIV Detection Tests:</b> (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		
<b>Viral Load Test:</b> ( <u>most recent</u> test- mm/dd/yyyy)			<b>Immunologic Lab Test:</b> (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			<b>First&lt;200 or &lt;14% of total lymphocytes</b>		
HIV-1 RNA bDNA			CD4 Count: _____ cells/ul ( _____ %)		
HIV-1 RNA Other					
<b>Was patient confirmed by a physician as:</b>					
HIV- infected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If <b>Yes</b> , enter date of diagnosis (mm/dd/yyyy)		
Not HIV- infected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If <b>Yes</b> , enter date of diagnosis (mm/dd/yyyy)		

**VII. CLINICAL STATUS**

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date	Det.	Pres.		Initial DxDate	Det.	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 <b>Yes</b> , 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							

