

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≤ 12 years of age at time of diagnosis)**I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.**

Patient's name (last, first, MI)		Telephone number ()	Social Security Number	
Address (number, street)		City	County	State
				ZIP code

Date form completed (mm/dd/yyyy)		II. Health Department Use Only		
Month	Day	Year	Report status	Reporting health department
			1 New	State patient number
			2 Update	City/county patient number
Soundex code	Date of birth (mm/dd/yyyy)	Gender	CLIA number	Lab report/Accession number
	Month Day Year	1 Male 2 Female		
				*Confidential C&T number

*Publicly funded confidential counseling and testing sites only

III. Demographic Information				
Diagnosis status at report (check one)	Age at Diagnosis Years Months	Current status	Date of death Month Day Year	State/Territory of death
3 Perinatally HIV exposed.....		1 Alive		
4 Confirmed HIV infection (not AIDS)...		2 Dead		
5 AIDS.....		9 Unknown		
6 Seroreverter.....		Was reason for initial HIV evaluation due to clinical signs and symptoms?		Date of initial evaluation for HIV infection Month Day Year
		1 Yes 0 No 9 Unknown		
Date of last medical evaluation Month Day Year				
ETHNICITY		RACE		COUNTRY OF BIRTH
1 Hispanic	American Indian/Alaskan Native	Asian	1 U.S.	9 Unknown
2 Not Hispanic nor Latino	Native Hawaiian/Other Pacific Islander	White	7 U.S. Territories (including Puerto Rico)	
	Black or African American	Unknown	8 Other (specify):	
Expanded race (specify):				
<input type="checkbox"/> Check here if HIV infection is presumed to have been acquired outside United States and Territories. Specify country:				
Residence at first diagnosis of HIV or AIDS: <input type="checkbox"/> Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.)				
City	County	State/Country	ZIP code	

IV. Facility of Diagnosis

Facility name		City	State/Country
Facility setting (check one)	Facility type (check one)		
1 Public 3 Federal	01 Physician, HMO	29 Community Health Center	31 Hospital, inpatient
2 Private 9 Unknown	22 Counseling and Testing Site	30 Correctional Facility	32 Hospital, outpatient
			88 Other (specify):
			99 Unknown

V. Patient/Maternal Risk History (Respond to all categories.)

Child's biological mother's HIV infection status (check one)			
HIV negative or no diagnosis:		HIV positive or AIDS diagnosis:	
1 Refused HIV testing	3 Before pregnancy with this child	6 Before the child's birth, exact period unknown	
2 Known to be uninfected after this child's birth (Alert city/county HIV/AIDS Surveillance)	4 During pregnancy with this child	7 After the child's birth	
9 HIV status unknown	5 At the time of delivery	8 HIV-infected, unknown when diagnosed	

Date of mother's first positive HIV confirmatory test: Month Year	Mother was counseled about HIV testing during this pregnancy, labor, or delivery: Yes No Unknown
	1 0 9

Before the diagnosis of HIV/AIDS, this child's biological mother had:		Before the diagnosis of HIV infection/AIDS, this child had:	
Yes No Unknown	1 0 9	Yes No Unknown	1 0 9
• Injected nonprescription drugs.....		• Received clotting factor for hemophilia/coagulation disorder.....	
• HETEROSEXUAL relations with:	Yes No Unknown	(Specify disorder): 1 Factor VIII (Hemophilia A)	
• Intravenous/injection drug user.....	1 0 9	2 Factor IX (Hemophilia B) 8 Other (specify):	
• Bisexual male.....	1 0 9	• Received transfusion of blood/components (other than clotting factor).....	Yes No Unknown
• Male with hemophilia/coagulation disorder.....	1 0 9		1 0 9
• Transfusion recipient with documented HIV infection.....	1 0 9	First: Month Year Last: Month Year	
• Transplant recipient with documented HIV infection.....	1 0 9		Yes No Unknown
• Male with AIDS or documented HIV Infection, risk not specified	1 0 9	• Received transplant of tissue/organs.....	1 0 9
• Male with perinatally-acquired HIV.....	1 0 9	• Sexual contact with a male.....	1 0 9
• Received transfusion of blood/blood components (other than clotting factor).....	Yes No Unknown	• Sexual contact with a female.....	1 0 9
	1 0 9	• Injected nonprescription drugs.....	1 0 9
• Received transplant of tissue/organs or artificial insemination.....	1 0 9	• Other (alert state/city NIR coordinator).....	1 0 9
• Perinatally-acquired HIV infection, regardless of mother's date of birth	1 0 9		

VI. Provider Information

Physician's name (last, first, MI)	Patient's medical record number	Person completing form	Physician's Telephone Number ()	
Address (number, street)		City	State	ZIP code

VII. Laboratory Data (Indicate the first positive test.)

1. HIV Antibody tests at initial diagnosis (Record all tests, include earliest positive.):

	Positive	Negative	Indeterminate	Not done	Month	Day	Year
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			

2. HIV Detection Tests (Record all tests, include earliest positive.)

	Positive	Negative	Not done	Month	Day	Year
HIV culture.....	1	0	9			
HIV culture.....	1	0	9			
HIV antigen test.....	1	0	9			
HIV antigen test.....	1	0	9			

	Positive	Negative	Not done	Month	Day	Year
HIV DNA PCR.....	1	0	9			
HIV DNA PCR.....	1	0	9			
HIV RNA PCR.....	1	0	9			
HIV RNA PCR.....	1	0	9			
Other, (specify) _____	1	0	9			

3. HIV Viral Load Test (Record earliest test.)

Test type*: ☐ Version*: ☐ Month ☐ Day ☐ Year ☐

Other (specify type and version): _____

Test result (Record in copies/mL and log₁₀ values.)

☐ Detectable Copies/mL:

Log₁₀:

Greater than: copies/mL

☐ Undetectable Less than: copies/mL

* Test type and version: 11 = NucliSens® HIV-1 QT (Organon-NASBA)
 12 = Amplior HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5
 13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0
 18 = Other (kit name/manufacturer/version) _____

4. Immunologic Lab Tests (At or closest to current diagnostic status.)

CD4 count cells/μl Month ☐ Day ☐ Year ☐

CD4 percent %

5. 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	No	Unknown
1	0	9

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

	Yes	No	Unknown	Month	Day	Year
HIV-infected.....	1	0	9			
Not HIV-infected.....	1	0	9			

VIII. Clinical Status (Def. = Definitive diagnosis / Pres. = Presumptive diagnosis)

AIDS Indicator Diseases	Initial Diagnosis Def. Pres.	Initial Date Month Year	AIDS Indicator Diseases	Initial Diagnosis Def. Pres.	Initial Date Month Year
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1 NA	<input type="text"/> <input type="text"/>	Kaposi's sarcoma	1 2	<input type="text"/> <input type="text"/>
Candidiasis, bronchi, trachea, or lungs	1 NA	<input type="text"/> <input type="text"/>	Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1 2	<input type="text"/> <input type="text"/>
Candidiasis, esophageal	1 2	<input type="text"/> <input type="text"/>	Lymphoma, Burkitt's (or equivalent term)	1 NA	<input type="text"/> <input type="text"/>
Coccidioidomycosis, disseminated or extrapulmonary	1 NA	<input type="text"/> <input type="text"/>	Lymphoma, immunoblastic (or equivalent term)	1 NA	<input type="text"/> <input type="text"/>
Cryptococcosis, extrapulmonary	1 NA	<input type="text"/> <input type="text"/>	Lymphoma, primary in brain	1 NA	<input type="text"/> <input type="text"/>
Cryptosporidiosis, chronic intestinal (>1 month duration)	1 NA	<input type="text"/> <input type="text"/>	Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1 2	<input type="text"/> <input type="text"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 month of age	1 NA	<input type="text"/> <input type="text"/>	M. tuberculosis, disseminated or extrapulmonary*	1 2	<input type="text"/> <input type="text"/>
Cytomegalovirus retinitis (with loss of vision)	1 2	<input type="text"/> <input type="text"/>	Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1 2	<input type="text"/> <input type="text"/>
HIV encephalopathy	1 NA	<input type="text"/> <input type="text"/>	Pneumocystis jiroveci pneumonia (PCP)	1 2	<input type="text"/> <input type="text"/>
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age	1 NA	<input type="text"/> <input type="text"/>	Progressive multifocal leukoencephalopathy	1 NA	<input type="text"/> <input type="text"/>
Histoplasmosis, disseminated or extrapulmonary	1 NA	<input type="text"/> <input type="text"/>	Toxoplasmosis of brain, onset at >1 month of age	1 2	<input type="text"/> <input type="text"/>
Isosporiasis, chronic intestinal (>1 month duration)	1 NA	<input type="text"/> <input type="text"/>	Wasting syndrome due to HIV	1 NA	<input type="text"/> <input type="text"/>

Has this child been diagnosed with pulmonary tuberculosis?*

1 Yes 0 No 9 Unknown

If yes, initial diagnosis:

1 Definitive 2 Presumptive

Date:

*RVCT case number

IX. Birth History (For *PERINATAL* cases only.)

Birth history was available for this child: ☐ 1 Yes ☐ 0 No ☐ 9 Unknown

If no or unknown, proceed to Section X.

Hospital at birth:	Name of hospital	Address (number, street)	City	County	State	ZIP code	Country
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Residence at birth:	City	County	State	ZIP code	Country
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<p>Birth weight (enter lbs/oz or grams)</p> <p><input type="text"/> <input type="text"/> lbs. <input type="text"/> <input type="text"/> oz.</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> grams</p>	<p>Birth Type: <input type="text"/> 1 Single <input type="text"/> 2 Twin <input type="text"/> 3 >2 <input type="text"/> 9 Unknown</p> <p>Delivery: <input type="text"/> 1 Vaginal <input type="text"/> 2 Elective Caesarean <input type="text"/> 3 Nonelective Caesarean <input type="text"/> 4 Caesarean, unknown type <input type="text"/> 9 Unknown</p> <p>Birth defects: <input type="text"/> 1 Yes <input type="text"/> 0 No <input type="text"/> 9 Unknown</p> <p>Specify type(s): _____ Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>Neonatal status: (99 = Unknown)</p> <p><input type="text"/> 1 Full term <input type="text"/> 2 Premature</p> <p><input type="text"/> <input type="text"/> weeks</p>	<p>Prenatal Care (99 = Unknown/00 = None)</p> <p>Months</p> <p>Month of pregnancy prenatal care began: <input type="text"/> <input type="text"/></p> <p>Total number of prenatal care visits: <input type="text"/> <input type="text"/></p>
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	Refused	Yes	No	Unknown
Did mother receive zidovudine (ZDV, AZT) during pregnancy?.....	8	1	0	9

If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? (99 = Unknown).....

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 weeks

	Refused	Yes	No	Unknown
Did mother receive zidovudine (ZDV, AZT) during labor/delivery?.....	8	1	0	9

	Yes	No	Unknown
Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?.....	1	0	9

	Yes	No	Unknown
Did mother receive any other anti-retroviral during pregnancy?.....	1	0	9

If yes, specify: _____

	Yes	No	Unknown
Did mother receive any other anti-retroviral medication during labor/delivery?.....	1	0	9

If yes, specify: _____

Biological Mother's date of birth			Biological Mother's Surname										Biological Mother's State Patient Number									
Month	Day	Year																				

Birthplace of biological mother

1 U.S. 7 U.S. Territories (including Puerto Rico) (specify): _____

8 Other (specify): _____ 9 Unknown

X. Treatment/Services Referrals

This child received or is receiving:

This child received or is receiving: Neonatal zidovudine (ZDV, AZT) for HIV prevention.....	Yes	No	Unknown	DATE STARTED		
	1	0	9	Month	Day	Year
Other neonatal anti-retroviral medication for HIV prevention.....	Yes	No	Unknown	Month	Day	Year
	1	0	9			

If yes, specify:

	DATE STARTED					
	Yes	No	Unknown	Month	Day	Year
Anti-retroviral therapy for HIV treatment.....	1	0	9			
PCP prophylaxis.....	1	0	9			

Was child breastfed?			This child has been enrolled at:				This child's medical treatment is primarily reimbursed by			
Yes	No	Unknown	<i>Clinical trial</i>		<i>Clinic</i>		1 Medicaid		4 Other public funding	
1	0	9	1 NIH-sponsored	2 Other	1 HRSA-sponsored	2 Other	2 Private insurance/HMO	7 Clinical trial/government program		
			3 None	9 Unknown	3 None	9 Unknown	3 No coverage	9 Unknown		

This child's primary caretaker is:

1 Biological 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 Unknown	

XI. Comments

[illegible]

**MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM
AT YOUR LOCAL HEALTH DEPARTMENT.**

LHD contact information is available on the website: www.cdph.ca.gov/AIDS

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