

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 <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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 CDCCenters for Disease Control
and Prevention (CDC)**Health Department Use Only (record all dates as mm/dd/yyyy)**

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

Date Received at Health Department ____/____/____		eHARS Document UID			State Number			
Reporting Health Dept—City/County				City/County Number				
Document Source			Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown					
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 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		<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<i>Outpatient:</i> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____		<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
Date Form Completed ____/____/____			*Person Completing Form			*Phone ()	

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

Diagnostic Status at Report <input type="checkbox"/> 3-Perinatal HIV exposure <input type="checkbox"/> 4-Pediatric HIV <input type="checkbox"/> 5-Pediatric AIDS <input type="checkbox"/> 6-Pediatric seroreverter			Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (please specify) _____		
Date of Birth ____/____/____				Alias Date of Birth ____/____/____			
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead		Date of Death ____/____/____			State of Death		
Date of Last Medical Evaluation ____/____/____				Date of Initial Evaluation for HIV ____/____/____			
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown					Expanded Ethnicity		
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown					Expanded Race		

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

Address Type (check all that apply to address below)						<input type="checkbox"/> Residence at HIV diagnosis		<input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis		<input type="checkbox"/> Residence at perinatal exposure		<input type="checkbox"/> Residence at pediatric seroreverter		<input type="checkbox"/> Check if SAME as current address	
*Street Address															
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.**

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).

STATE/LOCAL USE ONLY	
*Provider Name (Last, First, M.I.)	*Phone ()
Hospital/Facility	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Perinatal exposure <input type="checkbox"/> Check if <u>SAME</u> as facility providing information			
Facility Name		*Phone ()	
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type <u>Inpatient:</u> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____			
<u>Outpatient:</u> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____			
<u>Other Facility:</u> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> 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): <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> Known HIV+ at delivery <input type="checkbox"/> Known HIV+ after child's birth <input type="checkbox"/> HIV+, time of diagnosis unknown <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/____ Last date received ___/___/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Before the diagnosis of HIV infection, this child had:	
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specify clotting factor: _____ Date received ___/___/____	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/____ Last date received ___/___/____	
Received transplant of tissue/organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other documented risk (please include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	

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

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

HIV Immunoassays (Nondifferentiating)		
TEST 1 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	<input type="checkbox"/> Point-of-care rapid test
TEST 2 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	<input type="checkbox"/> Point-of-care rapid test
HIV Immunoassays (Differentiating)		
<input type="checkbox"/> HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result ¹ Overall interpretation: <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV negative	Collection Date ____/____/____	<input type="checkbox"/> Point-of-care rapid test
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	¹ Always complete the overall interpretation. Complete the analyte results when available.	
<input type="checkbox"/> 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 <input type="checkbox"/> Ag positive <input type="checkbox"/> Ab positive <input type="checkbox"/> Both (Ag and Ab positive) <input type="checkbox"/> Negative <input type="checkbox"/> Invalid	Collection Date ____/____/____	<input type="checkbox"/> Point-of-care rapid test
<input type="checkbox"/> 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: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index value _____		
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level <input type="checkbox"/> Index value _____ HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated <input type="checkbox"/> Index value _____ HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated <input type="checkbox"/> Index value _____		
Collection Date ____/____/____	<input type="checkbox"/> Point-of-care rapid test	² Complete the overall interpretation and the analyte results.
HIV Detection Tests (Qualitative)		
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	
HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis.		
TEST 1 <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable <input type="checkbox"/> Copies/mL _____	Log _____	Collection Date ____/____/____
TEST 2 <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)		
Test brand name/Manufacturer _____	Lab name _____	
Facility name _____	Provider name _____	
Result <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable <input type="checkbox"/> Copies/mL _____	Log _____	Collection Date ____/____/____
Drug Resistance Tests (Genotypic)		
TEST <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of diagnosis ____/____/____
	Not HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of diagnosis ____/____/____

Birth History (for Perinatal Cases only)

Residence at Birth	Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Check if <u>SAME</u> as current address
*Street Address		City	
County	State/Country		*ZIP Code
Facility of Birth	<input type="checkbox"/> Check if <u>SAME</u> as facility providing information		
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone ()	
Facility Type		<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____ <i>Outpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____ <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
*Street Address		City	
County	State/Country		*ZIP Code
Birth History	Birth Weight ____lbs ____oz ____grams		Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3-More than two <input type="checkbox"/> 9-Unknown
Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Nonelective Cesarean <input type="checkbox"/> 4-Cesarean, unknown type <input type="checkbox"/> 9-Unknown			
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, specify types	
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, specify all ARVs	
Date began ____/____/____ Date of last use ____/____/____			
Did mother receive any ARVs during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, specify all ARVs	
Date began ____/____/____ Date of last use ____/____/____			
Did mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		If yes, specify all ARVs	
Date began ____/____/____ Date of last use ____/____/____			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, reason for ARV use (select all that apply)			
<input type="checkbox"/> HIV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PrEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PEP	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> PMTCT	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> HBV Tx	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
<input type="checkbox"/> Other (specify reason) _____	ARV medications _____	Date began ____/____/____	Date of last use ____/____/____
Has this child ever taken PCP prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date began ____/____/____	Date of last use ____/____/____
Was this child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
This child's primary caretaker is <input type="checkbox"/> 1-Biological parent <input type="checkbox"/> 2-Other relative <input type="checkbox"/> 3-Foster/Adoptive parent, relative <input type="checkbox"/> 4-Foster/Adoptive parent, unrelated <input type="checkbox"/> 7-Social service agency <input type="checkbox"/> 8-Other (please specify in comments) <input type="checkbox"/> 9-Unknown			

Comments

***Local/Optional Fields**
