

DC Government, Department of Health

Pediatric HIV Case Report Form

Technical Guidance on Completing the Form

HIV/AIDS, Hepatitis, STD and TB Administration
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Section 1: Instructions for Completing the District of Columbia Department of Health Pediatric HIV Confidential Case Report Form (Clients <13 years of age at time of diagnosis)

Purpose of case report form

The Pediatric HIV/AIDS Confidential Case Report form is designed to collect information that promotes understanding of HIV infection and AIDS morbidity and mortality among District of Columbia residents younger than 13 years of age at time of diagnosis. This form reflects data that should be collected; this guidance applies to this data collection even if surveillance sites use a different form or medium for HIV/AIDS case surveillance. The information collected allows the DC DOH to monitor and evaluate care and prevention programs as well as assess the status of the epidemic. This form is to be used by health providers to fulfill their legal obligations to report HIV infections and AIDS conditions.

Clients for whom form is indicated

- Each person that is a new HIV (not AIDS) infection to you.
- Each person that is a new AIDS diagnosis to you.
- Each person previously reported as an HIV (not AIDS) infection that progresses to AIDS
- Each HIV-infected/AIDS client that dies, use this form to report the new information.

Definition of data field designators

- **Required:** Data fields that are required to meet the case definitions of HIV or AIDS, to identify and track cases, and to do meaningful statistical analysis.
- **Recommended:** Information that is useful for analysis but not essential for core surveillance.
- **Optional:** Information that should be ascertained if readily available.

Disposition of form

The completed form is for state or local health agency use and is not to be sent to the Centers for Disease Control and Prevention (CDC) with client identifiers.

Data obtained from these forms are entered into compatible or standardized computer software provided by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC, and then transferred without identifiers to CDC electronically by encrypted computer diskette or electronic transfer via secure data network.

Section 2: The District of Columbia Department of Health Pediatric HIV Confidential Case Report Form (Clients <13 years of age at time of diagnosis)

The numbers and letters in this document correspond to the spaces in the case report form (see Appendix A) The Roman numerals correspond to the sections of the case report form. The Arabic numbers correspond to the fields that may be completed by the health care provider, facility or investigator. Underneath the numbered fields, there are bulleted explanations of the fields that may also have listed answer options with their descriptions. The fields marked with the asterisks (*) are fields that are kept confidentially within the Department of Health and more specifically within the Strategic Information Bureau within the HIV/AIDS, Hepatitis, STD and TB Administration.

I. Health Department Use Only

1. **Date Rec'd at Health Department** (required)
 - Date that this form was received at the Health Department.
2. **Document Source** (required)
 - Indicate the source of the information used to complete this document. Refer to Appendix E for document source types.
3. **State No.** (required)
 - The unique State Number assigned to all confirmed HIV infected cases.
 - Indicate if this is a new report or an updated report.
4. **Did this report initiate a new case investigation?** (required)
 - Check one option that indicates if this initiated an investigation.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if this report is a new case investigation.
5. **Report Medium** (required)
 - Check one option that indicates how this report was received/retrieved.
 - a. **Field Visit:** The Department of Health visited a health care provider/facility to complete the case report form.
 - b. **Mailed:** The case report form was received via mail.
 - c. **Faxed:** The case report form was received via fax.
 - d. **Phone:** The case report form was dictated over the telephone.
 - e. **Electronic Transfer:** The case report form was completed by a computer interface or a secured file transfer protocol.
 - f. **CD/Disk:** The case report form was completed by a health care provider/facility and retrieved from a portable storage device.
6. **Surveillance Method** (required)
 - Check one option to indicate what method was used to obtain the information in this document.
 - a. **Active:** The main method is the Department of Health staff retrieved the information through interview or review of other documentation from a health care provider/facility.
 - b. **Passive:** The main method is the health care provider/facility completed the case report form.

- c. **Re-abstractation:** The main method is the Department of Health staff retrieved additional information on an existing case through interview or review of other documentation.
- d. **Follow up:** The main method is the Department of Health staff gathered additional information from another health care provider/facility that was identified during the previous investigation.
- e. **Unknown:** The report was received at the Department of Health and was unable to determine the method by which the information was obtained.

II. Facility Providing Information

This is the location that is completing the information on the form. This potentially may not be the same as the facility of diagnosis.

7. **Date Form Completed** (required)
 - The date a person at the facility is completing this form.
8. **Medical Record Number** (recommended)
 - The client's Medical Record Number.
9. **Person Completing Form** (required)
 - The name of the person at the facility that is completing this form.
10. **Phone Number** (required)
 - The phone number of the person at the facility/physician office that is completing this form.
11. **Facility Name** (required)
 - The name of the facility or physician office that is providing the information on this form.
12. **Facility ID** (required)
 - The identification number of the facility or physician office that is providing the information on this form.
13. **Phone** (required)
 - The phone number of the facility or physician office that is providing the information on this form.
14. **Street Address** (required)
 - The street address of the facility or physician office that is providing the information on this form.
15. **City** (required)
 - The name of the city where the facility or physician office that is providing the information on this form is located.
16. **County/Ward** (required)
 - The name of the county where the facility or physician office that is providing the information on this form is located.
17. **State/Country** (required)
 - The state (if not US, the country) where the facility or physician office that is providing the information on this form is located.
18. **ZIP Code** (required)

- The ZIP code where the facility or physician office that is providing the information on this form is located.
19. **Facility Type** (recommended)
- Indicate the facility type. Refer to the reference sheet on page 5 of the Pediatric HIV Case Report Form for a list of options (Appendix A).

III. Client Identification

The personal identifiers of the client are used for de-duplication, investigation, and linkage of clients to prevention, treatment and care services.

20. **First Name** (required)
- Client's first name.
21. **Middle Name** (optional)
- Client's middle name.
22. **Last Name** (required)
- Client's last name.
23. **Alternate First Name** (recommended)
- Client's first name, if there is another one used.
24. **Alternate Middle Name** (optional)
- Client's middle name, if there is another one used.
25. **Alternate Last Name** (recommended)
- Client's last name, if there is another one used.
26. **Phone** (required)
- If the client has a phone, the current phone number.
27. **Address Type** (required)
- Check one option that best describes the type of residence where the client is currently residing.
 - Residential:** Generally an address related to a home, condominium, apartment, or co-op
 - Bad Address:** Generally an address that is not recognized by the post office
 - Correctional Facility:** Generally an address associated with a jail or prison
 - Foster Home:** Generally an address associated with foster care
 - Homeless:** Generally there is no specific address
 - Postal:** Generally is an address associated with a Post Office Box
 - Shelter:** Generally is an address associated with a shelter for the homeless or displaced individuals
 - Temporary:** Generally an address that is not a permanent residence
28. **Current Street Address** (required)
- The address for where the client is currently residing.
29. **City** (required)
- The name of the city where the client is currently residing.
30. **County/Ward** (recommended)
- The name of the county (if DC, the Ward) where the client is currently residing.
31. **State/Country** (required)

- The state or country where the client is currently residing.
32. **ZIP Code** (required)
- The ZIP code for where the client is currently residing.
33. **Social Security Number** (recommended)
- The client's personal social security number.
34. **Other ID** (recommended)
- Indicate if there is another identification card, please specify the type. (The social security card is preferred for de-duplication purposes)
- 34a. **Other ID Number** (recommended)
- The unique number of the other type of identification listed in #34.

IV. Client Demographics

This is related to the client's identity and is highly useful in de-duplication and analysis and trends of the population.

35. **Diagnostic status at report** (required)
- The client's diagnosis at time of reporting.
 - a. **Preliminary Positive**
 - b. **Perinatal HIV Exposure**
 - c. **Pediatric HIV**
 - d. **Pediatric AIDS**
 - e. **Pediatric Seroreverter**
36. **Sex assigned at birth** (required)
- The sex of the client at the time of birth.
 - a. **Male:** Documented as male on birth certificate.
 - b. **Female:** Documented as female on birth certificate.
 - c. **Unknown:** Unable to obtain or ascertain sex at birth.
37. **Date of Birth** (required)
- The client's date of birth.
38. **Alias Date of Birth** (recommended)
- If the client has other dates of birth recorded in your records, please provide it.
39. **Country of Birth** (recommended)
- To ascertain if the client was born in the United States or elsewhere.
 - a. **US:** The client's birth occurred in any of the 50 states.
 - b. **Other/US Dependency:** If the client's birth did not occur in any of the 50 states, specify the country of birth.
40. **Vital Status** (required)
- Indicate the client's current disposition.
 - a. **Alive**
 - b. **Dead**
41. **Date of Death** (required)
- If the vital status chosen is dead, provide the client's date of death.
42. **State of Death** (recommended)
- If vital status chosen is dead, provide the location of where the client's death occurred.
43. **Date of Last Medical Evaluation** (required)

- The date the client was last medically evaluated.
44. **Date of Initial Evaluation for HIV infection** (required)
- The date of the client's initial evaluation for HIV infection.
45. **Ethnicity** (required)
- Best describes the client's ethnic origin.
 - a. **Hispanic or Latino:** Client is of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
 - b. **Not Hispanic or Not Latino:** Client is not of Hispanic or Latino ethnicity.
 - c. **Unknown:** Client's ethnicity was not determined.
46. **Expanded Ethnicity** (recommended)
- If the client selects Hispanic/Latino, see Appendix D for ethnic categories.
47. **Race** (required)
- Best describes the client's racial identity.
 - a. **American Indian/Alaskan Native:** Client having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
 - b. **Asian:** Client having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
 - c. **Black/African American:** Client having origins in any of the black racial groups of Africa.
 - d. **Native Hawaiian/Pacific Islander:** Client having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
 - e. **White:** Client having origins in any of the original peoples of Europe, the Middle East, or North Africa.
 - f. **Unknown:** Client's origins were not determined.
48. **Expanded Race** (recommended)
- See Appendix C for racial categories.

V. Residence at Diagnosis

This is associated with the earliest known date for confirmation of HIV infection or AIDS condition.

49. **Address Type** (required)
- This address can be different than the current address because it is dependent upon the time of diagnosis of HIV infection or AIDS condition.
 - a. **Residence at HIV Diagnosis:** Associated with the earliest known date that HIV infection was confirmed.
 - b. **Residence at AIDS Diagnosis:** Associated with the earliest known date that AIDS was confirmed. Please note that if a client is initially diagnosed with AIDS, HIV must also be checked.
 - c. **Residence at Perinatal Exposure:** Associated address of perinatal exposure.
 - d. **Residence at Pediatric Seroreverter:** Associated address of pediatric seroreverter.
 - e. **Check if SAME as Current Address:** If the address at HIV or AIDS diagnosis is the same as the current address.
50. **Street Address** (required)
- The client's street address at time of HIV and/or AIDS diagnosis.

51. **City** (required)
 - The client's city at the time of HIV and/or AIDS diagnosis.
52. **County/Ward** (required)
 - The client's county (if DC, the Ward) at the time of HIV and/or AIDS diagnosis.
53. **State/Country** (required)
 - The client's state (if not US, the country) at the time of HIV and/or AIDS diagnosis.
54. **ZIP Code** (required)
 - The client's ZIP code at the time of HIV and/or AIDS diagnosis.

VI. Facility of Diagnosis

This is associated with the earliest known date for confirmation of HIV infection or AIDS condition and can be different from the facility completing the report form.

55. **Diagnosis type** (required)
 - This depends upon the client's HIV infection status and where the diagnosis was made. The address for HIV infection, AIDS, and current residence can all be different, the same, or a combination.
 - a. **HIV:** If the client is HIV infected only, this box is checked and the facility information will correspond.
 - b. **AIDS:** If the client has AIDS, this box is checked and the facility information will correspond. Please note that if a client is initially diagnosed with AIDS, HIV must also be checked.
 - c. **Perinatal Exposure:** If perinatal exposed client, this box is checked and the facility information will correspond.
 - d. **Check if SAME as Facility Providing Information:** If the facility of diagnosis is the same as the facility completing this form, this box is checked and it will not be necessary to complete the facility identifying information.
56. **Facility name** (required)
 - The name of the facility or physician office where the client's HIV infection and/or AIDS condition was diagnosed.
57. **Phone** (required)
 - The phone number of the facility where the client's HIV infection and/or AIDS condition was diagnosed.
58. **Street Address** (required)
 - The street address of the facility where the client's HIV infection and/or AIDS condition was diagnosed.
59. **City** (required)
 - The name of the city of the facility where the client's HIV infection and/or AIDS condition was diagnosed.
60. **County/Ward** (required)
 - The name of the county of the facility where the client's HIV infection and/or AIDS condition was diagnosed.
61. **State/Country** (required)

- The name of the state of the facility (if not US, the country) where the client's HIV infection and/or AIDS condition was diagnosed.
62. **ZIP code** (required)
- The zip code of the facility where the client's HIV infection and/or AIDS condition was diagnosed.
63. **Facility type** (required)
- Indicate the facility type the client's HIV infection and/or AIDS condition was diagnosed. Refer to the reference sheet on page 5 of the Pediatric HIV Case Report Form for a list of options (Appendix A).
64. **Provider Name** (required)
- The name of the provider at the facility where the client's HIV infection and/or AIDS condition was diagnosed.
65. **Provider Phone** (required)
- The phone number of the provider at the facility where the client's HIV infection and/or AIDS condition was diagnosed.
66. **Specialty** (optional)
- The provider's specialty at the facility where the client's HIV infection and/or AIDS condition was diagnosed.

VII. Client History

Attempt to ascertain behavioral risk factors.

67. **Child's biological mother's HIV Infection status** (required)
- Indicate the child's biological mother's HIV infection status.
 - a. **Refused HIV Testing**
 - b. **Known to be uninfected after this child's birth**
 - c. **Known HIV+ before pregnancy**
 - d. **Known HIV+ during pregnancy**
 - e. **Known HIV+ at delivery**
 - f. **Known HIV+ after child's birth**
 - g. **HIV+, time of diagnosis unknown**
 - h. **HIV status unknown**
68. **Date of Mother's first positive HIV confirmatory test** (required)
- The date of the child's mother's first positive HIV confirmatory test.
69. **Was the biological mother counseled about HIV testing during this pregnancy, labor or delivery?** (required)
- Indicate if the child's biological mother was counseled about HIV testing during the pregnancy, labor or delivery.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother was counseled about HIV testing during the pregnancy, labor or delivery.

After 1977 and before the earliest known diagnosis of HIV infection, the client had...

70. **Perinatally acquired HIV infection** (required)
- Indicate if the child's biological mother had a perinatally acquired HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother had a perinatally acquired HIV infection.
71. **Used injected non-prescription drugs** (required)
- Indicate if the child's biological mother used injected non-prescription drugs.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother had used injected non-prescription drugs.
72. **Vaginal sex with a male...** (required)
- Indicate if the child's biological mother has had vaginal sex with a male. If yes to #72, please answer #72a-72f.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male after 1977 and before earliest known HIV diagnosis.
- 72a. **Without using a condom** (required)
- Indicate if the child's biological mother has had vaginal sex with a male, without use of a condom.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male without a condom after 1977 and before earliest known HIV diagnosis.
- 72b. **Who is an IDU** (required)
- Indicate if the child's biological mother has had vaginal sex with a male who is an IDU.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who is an IDU after 1977 and before earliest known HIV diagnosis.
- 72c. **Who is HIV +** (required)
- Indicate if the child's biological mother has had vaginal sex with a male who is known to be HIV positive.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who is known to be HIV positive after 1977 and before earliest known HIV diagnosis.
- 72d. **With hemophilia/coagulation disorder with documented HIV infection** (required)
- Indicate if the child's biological mother has had vaginal sex with a male who is known to have hemophilia/coagulation disorder, and a documented HIV infection.

- a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has hemophilia/coagulation disorder, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 72e. **With transfusion recipient with documented HIV infection** (required)
- Indicate if the child's biological mother has had vaginal sex with a male who has received a blood transfusion, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has received a blood transfusion, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 72f. **With transplant recipient with documented HIV infection** (required)
- Indicate if the child's biological mother has had vaginal sex with a male who has received a transplant, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has received a transplant, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
73. **Anal sex with a male** (required)
- Indicate if the child's biological mother has had anal sex with a male. If yes to #73, please answer #73a-73f.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male after 1977 and before earliest known HIV diagnosis.
- 73a. **Without using a condom** (required)
- Indicate if the child's biological mother has had anal sex with a male, without use of a condom.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male without a condom after 1977 and before earliest known HIV diagnosis.
- 73b. **Who is an IDU** (required)
- Indicate if the child's biological mother has had anal sex with a male who is an IDU.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who is an IDU after 1977 and before earliest known HIV diagnosis.
- 73c. **Who is HIV +** (required)
- Indicate if the child's biological mother has had anal sex with a male who is known to be HIV positive.
 - a. **Yes**
 - b. **No**

- c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who is known to be HIV positive after 1977 and before earliest known HIV diagnosis.
- 73d. **With hemophilia/coagulation disorder with documented HIV infection** (required)
- Indicate if the child's biological mother has had anal sex with a male who is known to have hemophilia/coagulation disorder, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has hemophilia/coagulation disorder, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 73e. **With transfusion recipient with documented HIV infection** (required)
- Indicate if the child's biological mother has had anal sex with a male who has received a blood transfusion, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has received a blood transfusion, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 73f. **With transplant recipient with documented HIV infection** (required)
- Indicate if the child's biological mother has had anal sex with a male who has received a transplant, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a male who has received a transplant, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
74. **Vaginal sex with a transgendered individual** (required)
- Indicate if the child's biological mother has had vaginal with a transgendered individual. If yes to #74, please answer #74a-74f.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual after 1977 and before earliest known HIV diagnosis.
- 74a. **Without using a condom** (required)
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual, without use of a condom.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual without a condom after 1977 and before earliest known HIV diagnosis.
- 74b. **Who is an IDU** (required)
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual who is an IDU.
 - a. **Yes**
 - b. **No**

- c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who is an IDU after 1977 and before earliest known HIV diagnosis.
- 74c. **Who is HIV + (required)**
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual who is known to be HIV positive.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who is known to be HIV positive after 1977 and before earliest known HIV diagnosis.
- 74d. **With hemophilia/coagulation disorder with documented HIV infection (required)**
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual who is known to have hemophilia/coagulation disorder, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has hemophilia/coagulation disorder, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 74e. **With transfusion recipient with documented HIV infection (required)**
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual who has received a blood transfusion, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has received a blood transfusion, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
- 74f. **With transplant recipient with documented HIV infection (required)**
- Indicate if the child's biological mother has had vaginal sex with a transgendered individual who has received a transplant, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has received a transplant, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
75. **Anal sex with a transgendered individual (required)**
- Indicate if the child's biological mother has had anal sex with a transgendered individual. If yes to #75, please answer #75a-75f.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual after 1977 and before earliest known HIV diagnosis.

75a. **Without using a condom** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual, without use of a condom.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual without a condom after 1977 and before earliest known HIV diagnosis.

75b. **Who is an IDU** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual who is an IDU.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who is an IDU after 1977 and before earliest known HIV diagnosis.

75c. **Who is HIV +** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual who is known to be HIV positive.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who is known to be HIV positive after 1977 and before earliest known HIV diagnosis.

75d. **With hemophilia/coagulation disorder with documented HIV infection** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual who is known to have hemophilia/coagulation disorder, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has hemophilia/coagulation disorder, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.

75e. **With transfusion recipient with documented HIV infection** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual who has received a blood transfusion, and a documented HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has received a blood transfusion, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.

75f. **With transplant recipient with documented HIV infection** (required)

- Indicate if the child's biological mother has had anal sex with a transgendered individual who has received a transplant, and a documented HIV infection.
 - a. **Yes**
 - b. **No**

- c. **Unknown:** Unable to determine if the child's biological mother has had sex with a transgendered individual who has received a transplant, and a documented HIV infection after 1977 and before earliest known HIV diagnosis.
76. **Vaginal sex with an MSM** (required)
- Indicate if the child's biological mother has had vaginal sex with a man who has sex with men.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with an MSM after 1977 and before earliest known HIV diagnosis.
77. **Anal sex with an MSM** (required)
- Indicate if the child's biological mother has had anal sex with a man who has sex with men.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has had sex with an MSM after 1977 and before earliest known HIV diagnosis.
78. **Received transfusion of blood/blood components (other than clotting factor)** (required)
- Indicate if the child's biological mother has received transfusion of blood/blood components. Document reasons in Comments section.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has received transfusion of blood/blood components after 1977 and before earliest known HIV diagnosis.
- 78a. **If Yes, first date received** (required)
- The first date the blood/blood components were given.
- 78b. **If Yes, last date received** (required)
- The last date the blood/blood components were given.
79. **Received transplant of tissue/organs or artificial insemination** (required)
- Indicate if the child's biological mother has received transplant of tissue/organs or artificial insemination.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother has received transplant of tissue/organs or artificial insemination after 1977 and before earliest known HIV diagnosis.

Before the diagnosis of HIV infection, this child had...

80. **Injected non-prescription drugs** (required)
- Indicate if the child has injected non-prescription drugs before the diagnosis of HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child has injected non-prescription drugs before the diagnosis of HIV infection.

81. **Received clotting factor for hemophilia/coagulation disorder** (required)
- Indicate if the child has received clotting factor for hemophilia/coagulation disorder before the diagnosis of HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child has received clotting factor for hemophilia/coagulation disorder before the diagnosis of HIV infection.
- 81a. **If yes, specify the clotting factor** (required)
- The name of the clotting factor given to the child.
- 81b. **If yes, specify date received** (required)
- The date of the clotting factor given to the child.
82. **Received transfusion of blood/blood components (other than clotting factor)** (required)
- Indicate if child has received transfusion of blood/blood components before the diagnosis of HIV infection. Document reasons in Comments section.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child had received transfusion of blood/blood components before the diagnosis of HIV infection.
- 82a. **If yes, first date received** (required)
- First date the blood/blood components were given.
- 82b. **If yes, last date received** (required)
- The last date the blood/blood components were given.
83. **Received transplant of tissue/organs** (required)
- Indicate if the child had received transplant of tissues/organs before the diagnosis of HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determined if the child had received transplant of tissues/organs before the diagnosis of HIV infection.
84. **Sexual contact with male** (required)
- Indicate if the child had sexual contact with a male before the diagnosis of HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determined if the child had sexual contact with a male before the diagnosis of HIV infection.
85. **Sexual contact with female** (required)
- Indicate if the child had sexual contact with a female before the diagnosis of HIV infection.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determined if the child had sexual contact with a female before the diagnosis of HIV infection.
86. **Other documented risk** (required)
- Indicate if the client has another documented risk.
 - a. **Yes:** Please include detail in the Comments section.
 - b. **No**
 - c. **Unknown:** Unable to determine if there is another documented risk.

HEATH DEPARTMENT USE ONLY

87. **Is this an NIR/NRR case?** (required)

- Indicate if this is a No Identified Risk (NIR) or No Risk Reported (NRR) case.
 - a. **Yes:** There was no identified risk reported.
 - b. **No:** Risk was reported.
 - c. **Unknown:** There was no attempt to ascertain risk or it was not noted.

87a. **If No Risk Reported, indicate date investigation was completed** (required)

- The date the investigation was completed.

VIII. Laboratory Data (required, if done)

HIV Antibody Tests at Diagnosis (non-type differentiating)

Test 1:

88. **Type:** (required)

- Indicate test type.
 - a. **HIV-1 EIA:** Electroimmunoassay
 - b. **HIV-1/2 EIA:** Electroimmunoassay
 - c. **HIV- 1/2 Ag/Ab:** Antigen-Antibody Combo Assay
 - d. **HIV-1 WB:** Western Blot
 - e. **HIV-1 IFA:** Immunoflourescence Assay
 - f. **HIV-2 EIA:** Electroimmunoassay
 - g. **HIV-2 WB:** Western Blot
 - h. **Other:** If not listed in the options, please specify the type of test.

89. **Result:** (required)

- Indicate lab result.
 - a. **Positive/Reactive**
 - b. **Negative/Nonreactive**
 - c. **Indeterminate**

90. **Rapid Test:** (required)

- If the test indicated in #88 was a rapid test, check the box.

91. **Collection date:** (required)

- The date of the specimen collection.

92. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

93. **Manufacturer** (recommended)

- The manufacturer of the lab test.

Test 2:

94. **Type:** (required)
- Indicate test type.
 - a. **HIV-1 EIA:** Electroimmunoassay
 - b. **HIV-1/2 EIA:** Electroimmunoassay
 - c. **HIV- 1/2 Ag/Ab:** Antigen-Antibody Combo Assay
 - d. **HIV-1 WB:** Western Blot
 - e. **HIV-1 IFA:** Immunoflourescence Assay
 - f. **HIV-2 EIA:** Electroimmunoassay
 - g. **HIV-2 WB:** Western Blot
 - h. **Other:** If not listed in the options, please specify the type of test.
95. **Result:** (required)
- Indicate lab result.
 - a. **Positive/Reactive**
 - b. **Negative/Nonreactive**
 - c. **Indeterminate**
96. **Rapid Test:** (required)
- If the test indicated in #94 was a rapid test, check the box.
97. **Collection date:** (required)
- The date of the specimen collection.
98. **Accession #:** (recommended)
- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.
99. **Manufacturer** (recommended)
- The manufacturer of the lab test.

Test 3:

100. **Type:** (required)
- Indicate test type.
 - a. **HIV-1 EIA:** Electroimmunoassay
 - b. **HIV-1/2 EIA:** Electroimmunoassay
 - c. **HIV- 1/2 Ag/Ab:** Antigen-Antibody Combo Assay
 - d. **HIV-1 WB:** Western Blot
 - e. **HIV-1 IFA:** Immunoflourescence Assay
 - f. **HIV-2 EIA:** Electroimmunoassay
 - g. **HIV-2 WB:** Western Blot
 - h. **Other:** If not listed in the options, please specify the type of test.
101. **Result:** (required)
- Indicate lab result.
 - a. **Positive/Reactive**
 - b. **Negative/Nonreactive**
 - c. **Indeterminate**
102. **Rapid Test:** (required)
- If the test indicated in #84 was a rapid test, check the box.
103. **Collection date:** (required)
- The date of the specimen collection.

104. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

105. **Manufacturer** (recommended)

- The manufacturer of the lab test.

HIV Antibody Tests at Diagnosis (type differentiating)

Test:

106. **Type:** (required)

- Indicate test type.
 - a. **HIV-1/2 Differentiating (e.g., Multispot)**

107. **Result:** (required)

- Indicate lab result.
 - a. **HIV-1**
 - b. **HIV-2**
 - c. **Both (undifferentiated)**
 - d. **Neither (negative)**
 - e. **Indeterminate**

108. **Collection Date:** (required)

- The date of the specimen collection.

109. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

HIV Antibody Detection Tests

Test 1:

110. **Type:** (required)

- Indicate test type.
 - a. **HIV-1 p24 Antigen**
 - b. **HIV-1 RNA/DNA NAAT (Qual)**
 - c. **HIV-1 Culture**
 - d. **HIV-2 RNA/DNA NAAT (Qual)**
 - e. **HIV-2 Culture**

111. **Result:** (required)

- Indicate lab result.
 - a. **Positive/Reactive**
 - b. **Negative/Nonreactive**
 - c. **Indeterminate**

112. **Collection Date:** (required)

- The date of the specimen collection.

113. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

Test 2:

114. **Type:** (required)

- Indicate test type.
 - a. **HIV-1 p24 Antigen**
 - b. **HIV-1 RNA/DNA NAAT (Qual)**
 - c. **HIV-1 Culture**
 - d. **HIV-2 RNA/DNA NAAT (Qual)**
 - e. **HIV-2 Culture**

115. **Result:** (required)

- Indicate lab result.
 - a. **Positive/Reactive**
 - b. **Negative/Nonreactive**
 - c. **Indeterminate**

116. **Collection Date:** (required)

- The date of the specimen collection.

117. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

Immunologic Lab Tests

At or closest to current diagnosis status:

118. **CD4 Count** (required)

- To be reported as cell per microliter.

119. **CD4 Count** (required)

- To be reported as a percent.

120. **Collection Date:** (required)

- The date of the specimen collection.

121. **Accession #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

First <200 μ L or <14%:

122. **CD4 Count** (required)

- To be reported as cell per microliter.

123. **CD4 Count** (required)

- To be reported as a percent.

124. **Collection Date:** (required)

- The date of the specimen collection.

125. **Ascension #:** (recommended)

- Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

Viral Load Tests

Test 1: (Most Recent)

126. **Result:** (required)

- Indicate lab result.
 - a. **Detectable:** Virus was detected.
 - b. **Undetectable:** Virus was not detected.

- 127. **Copies/μL** (required)
 - The number of virus found in the specimen.
- 128. **Log** (required)
 - The number of virus found in the specimen.
- 129. **Collection Date:** (required)
 - The date of the specimen collection.
- 130. **Accession #:** (recommended)
 - Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.

Test 2: (Earliest)

- 131. **Result:** (required)
 - Indicate lab result.
 - a. **Detectable:** Virus was detected.
 - b. **Undetectable:** Virus was not detected.
- 132. **Copies/μL** (required)
 - The number of virus found in the specimen.
- 133. **Log** (required)
 - The number of virus found in the specimen.
- 134. **Collection Date:** (required)
 - The date of the specimen collection.
- 135. **Accession #:** (recommended)
 - Every laboratory assigns an ascension number to a lab specimen and should be available with the test result.
- 136. **Did document laboratory test results meet approved HIV diagnostic algorithm criteria?** (recommended)
 - Indicate if the laboratory test results meet approved HIV diagnostic algorithm criteria.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the laboratory test results meet approved HIV diagnostic algorithm criteria.
- 136a. **If Yes, provide date (specimen collection date if known) of earliest positive test for this algorithm:** (recommended)
 - The date of the earliest positive test for the approved HIV diagnostic algorithm.

If HIV laboratory tests were not documented, is the client confirmed by a physician as:

- 137. **HIV-Not Infected** (required)
 - Indicate if the client was confirmed HIV-not infected by a physician.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client was confirmed HIV-not infected by a physician.
- 137a. **HIV- Infected** (required)
 - Indicate if the client was confirmed HIV-infected by a physician.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client was confirmed HIV-infected by a physician.

- 137b. **If Yes to #137a, provide date of documentation by physician** (required)
- Indicate the date of HIV infection documentation by physician.
138. **Genotyping Date:** (recommended)
- Enter the date of the genotyping test. If possible, retrieve a copy of the results.
139. **Phenotyping Date:** (recommended)
- Enter the date of the phenotyping test. If possible, retrieve a copy of the results.

IX. Clinical

These are AIDS-defining conditions that if found in an HIV infected client must be reported as either Definitive or Presumptive diagnosis where designated along with the date of diagnosis. If the client does not have an AIDS-defining condition, you may leave this section blank.

140. **Bacterial Infection, multiple or recurrent (including salmonella septicemia)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
141. **Candidiasis, bronchi, trachea, or lungs** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
142. **Candidiasis, esophageal** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of the diagnosis
143. **Coccidiomycosis, disseminated or extrapulmonary** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
144. **Cryptococcosis, extrapulmonary** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
145. **Cryptosporidiosis, chronic intestinal (>1 mo. duration)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
146. **Cytomegalovirus disease (other than in liver, spleen, or nodes)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
147. **Cytomegalovirus retinitis (with loss of vision)** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
148. **HIV encephalopathy** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of the diagnosis
149. **Herpes simplex: chronic ulcers (>1 mo. duration) bronchitis, pneumonitis, or esophagitis** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis

150. **Histoplasmosis, disseminated or extrapulmonary** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
151. **Isosporiasis, chronic intestinal (>1 mo. duration)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
152. **Kaposi's sarcoma** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
153. **Lymphoid interstitial pneumonia and/or pulmonary lymphoid** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
154. **Lymphoma, Burkitt's (or equivalent)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
155. **Lymphoma, immunoblastic (or equivalent)** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
156. **Lymphoma, primary in brain** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
157. **Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
158. **M. tuberculosis, disseminated or extrapulmonary** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** the Date of diagnosis
159. **Mycobacterium, of other/unidentified species, disseminated or extrapulmonary** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
160. **Pneumocystis carinii pneumonia** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of diagnosis
161. **Progressive multifocal leukoencephalopathy** (recommended)
- D:** Must be a definitive diagnosis
 - Date:** Date of diagnosis
162. **Toxoplasmosis of brain, onset at >1 mo. of age** (recommended)
- D:** Can be a definitive diagnosis or
 - P:** Can be a presumptive diagnosis
 - Date:** Date of the diagnosis

163. **Wasting syndrome due to HIV** (recommended)
- a. **D:** Must be a definitive diagnosis
 - b. **Date:** Date of diagnosis
164. Has this child been diagnosed with pulmonary tuberculosis (recommended)
- Indicate if the child has been diagnosed with pulmonary tuberculosis.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child has been diagnosed with pulmonary tuberculosis.
- 164a. **If yes, indicate if diagnosis is definitive or presumptive** (recommended)
- Indicate if the child’s pulmonary tuberculosis diagnosis is definitive or presumptive.
 - a. **Definitive:** Can be a definitive diagnosis or
 - b. **Presumptive:** Can be a presumptive diagnosis
 - c. **Unknown:** Unable to determine if diagnosis is definitive or presumptive.
- 164b. **Date** (recommended)
- Indicate the date the child was diagnosed with pulmonary tuberculosis.
- 164c. **If TB selected above, indicate RVCT Case Number** (recommended)
- Indicate the child’s RVCT Case Number.

X. Birth History (for Perinatal Cases Only)

165. **Birth History Available?** (required)
- Indicate if the child’s birth history is available.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child’s birth history is available.

Residence at Birth

Indicate the client’s residence at birth. If the residence is the same as the current address, check the “SAME as current address” option. If the residence is not the same, fill out the following.

166. **Street Address** (recommended)
- The street address of the client’s residence at birth.
167. **City** (recommended)
- The name of the city of the client’s residence at birth.
168. **County/Ward** (recommended)
- The name of the county of the client’s residence at birth.
169. **State/Country** (recommended)
- The state (if not US, the country) of the client’s residence at birth.
170. **ZIP Code** (recommended)
- The ZIP code of the client’s residence at birth.

Hospital at Birth

171. **Facility Name** (recommended)
- The name of the facility where the client was born.
172. **Phone** (recommended)
- The phone number of the facility where the client was born.

173. **Street Address** (recommended)
- The street address of the facility where the client was born.
174. **City** (recommended)
- The city of the facility where the client was born.
175. **County/Ward** (recommended)
- The county of the facility where the client was born.
176. **State/Country** (recommended)
- The state (if not US, the country) of the facility where the client was born.
177. **ZIP Code** (recommended)
- The ZIP code of the facility where the client was born.

Birth History

178. **Birth weight** (recommended)
- The weight of the child in pounds and ounces.
179. **Birth Type** (recommended)
- Indicate the birth type.
 - a. **Single:** Client was the only child born.
 - b. **Twin:** Two children were born.
 - c. **2:** More than two children were born.
 - d. **Unknown:** Unable to determine the birth type.
180. **Delivery** (recommended)
- Indicate the form of delivery.
 - a. **Vaginal:** The form of delivery was vaginal.
 - b. **Elective Cesarean:** The biological mother requested the cesarean delivery.
 - c. **Non-elective Cesarean:** Medical indications required mother to have a cesarean delivery.
 - d. **Cesarean, unknown type:** The form of delivery was cesarean; however, it is undetermined whether this was an elective or non-elective cesarean.
 - e. **Unknown:** Unable to determine form of delivery.
181. **Birth defects** (recommended)
- Indicate if there were any birth defects.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if there were any birth defects.
- 181a. **If yes, please specify** (recommended)
- Indicate the specific birth defects.
182. **Neonatal Status** (recommended)
- Indicate the child's neonatal status.
 - a. **Full-term:** Biological mother carried the child for 37-40 weeks.
 - b. **Pre-mature:** Biological mother carried the child for under 37 weeks.
 - c. **Unknown:** Unable to determine the client's neonatal status.
183. **Neonatal Status Weeks** (recommended)
- Indicate the number of weeks of the pregnancy. If unknown, use 99. If none, use 00.
184. **Prenatal Care-month of pregnancy prenatal care began** (recommended)
- Indicate in which month of pregnancy that the mother began prenatal care. If unknown, use 99. If none, use 00.

- 184a. **Prenatal Care- total number of prenatal care visits** (recommended)
- Indicate the total number of prenatal care visits. If unknown, use 99. If none, use 00.
185. **Did mother receive zidovudine (ZDV, AZT) during pregnancy?** (recommended)
- Indicate if the child's biological mother received zidovudine during the pregnancy.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother received zidovudine during the pregnancy.
- 185a. **If yes, what week of pregnancy was zidovudine (ZDV,AZT) started?** (recommended)
- Indicate during which week of pregnancy the client's biological mother started zidovudine.
186. **Did mother receive zidovudine (ZDV, AZT) during labor/delivery?** (recommended)
- Indicate if the child's biological mother received zidovudine during labor/delivery.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother received zidovudine during labor/delivery.
187. **Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?** (recommended)
- Indicate if the child's biological mother received zidovudine prior to this pregnancy.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother received zidovudine prior to this pregnancy.
188. **Did mother receive any other Anti-retroviral medication during pregnancy?** (recommended)
- Indicate if the child's biological mother received any other Anti-retroviral medication during the pregnancy.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother received any other Anti-retroviral medication during the pregnancy.
- 188a. **If yes, please specify** (recommended)
- Indicate any other Anti-retroviral medication received during the pregnancy.
189. **Did mother receive any other Anti-retroviral medication during labor/delivery?** (recommended)
- Indicate if the child's biological mother received any other Anti-retroviral medication during labor/delivery.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the child's biological mother received any other Anti-retroviral medication during labor/delivery.
- 189a. **If yes, please specify** (recommended)
- Indicate any other Anti-retroviral medication the child's biological mother received during labor/delivery.

Maternal Information

190. **Maternal DOB** (required)
- Indicate the child's biological mother's date of birth.

- 191. **Maternal Soundex/Name** (required)
 - Indicate the child's biological mother's Soundex/Name.
- 192. **Maternal State No** (required)
 - Indicate the child's biological mother's State ID number.
- 193. **Maternal Country of Birth** (required)
 - Indicate the child's biological mother's country of birth.
- 194. **Other maternal ID- List Type** (required)
 - Indicate the child's biological mother's other type of ID.
- 195. **Number** (required)
 - Indicate the child's biological mother's other ID number.

XI. Treatment/Services Referrals

The child received or is receiving...

- 196. **Neonatal zidovudine** (ZDV, AZT) for HIV Prevention (required)
 - Indicate if the client received neonatal zidovudine (ZDV, AZT) for HIV Prevention.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client received neonatal zidovudine (ZDV, AZT) for HIV Prevention.
- 196a. If Yes, date received (required)
 - The date neonatal zidovudine was taken.
- 197. Other neonatal anti-retroviral medication for HIV Prevention (required)
 - Indicate if the client received other neonatal anti-retroviral medication for HIV Prevention.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client received other neonatal anti-retroviral medication for HIV Prevention.
- 197a. If Yes, date received (required)
 - The date other neonatal anti-retroviral medication was taken.
- 197b. If Yes, please specify medication (required)
 - Specify the other anti-retroviral medications taken.
- 198. **Anti-retroviral therapy for HIV treatment** (required)
 - Indicate if the client received or is receiving anti-retroviral therapy for HIV treatment.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client received or is receiving anti-retroviral therapy for HIV treatment.
- 198a. If Yes, date received (required)
 - The date anti-retroviral therapy for HIV treatment was taken.
- 199. **PCP Prophylaxis** (required)
 - Indicate if the client received or is receiving PCP Prophylaxis.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client received or is receiving PCP Prophylaxis.

- 199a. **If Yes, date received** (required)
- The date the client received PCP Prophylaxis.
200. **Was the child breastfed?** (required)
- Indicate if the client was breastfed.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client was breastfed.
201. **This patient has been enrolled at:** (optional)
- Indicate if the client has been enrolled in either a clinical trial or a clinic. Specify in the Comment section.
 - a. **Clinical Trial**
 - b. **Clinic**
202. **At time of HIV diagnosis, medical treatment primarily reimbursed by:** (optional)
- Indicate how medical treatment is primarily reimbursed at the time of HIV diagnosis. Refer to the reference sheet on page 5 of the Adult Case Report Form for a list of options (Appendix A).
203. **At time of AIDS diagnosis, medical treatment primarily reimbursed by:** (optional)
- Indicate how medical treatment is primarily reimbursed at the time of AIDS diagnosis. Refer to the reference sheet on page 5 of the Adult Case Report Form for a list of options (Appendix A).
204. **Is the client receiving any of the following treatment reimbursements?** (optional)
- Indicate if the client is receiving any of the following reimbursements.
 - a. **ADAP**
 - b. **Alliance**
 - c. **Medicare**
205. **The child's primary caretaker** (required)
- Indicate the child's primary caretaker.
 - a. **Biological parent**
 - b. **Other relative**
 - c. **Foster/Adoptive parent, relative**
 - d. **Foster/Adoptive parent, unrelated**
 - e. **Social Service Agency**
 - f. **Other:** If the child's primary caretaker is someone other than the above, please specify in the comment section.
 - g. **Unknown:** Unable to determine who is the child's primary caretaker.

Co-infections: Provide information for previous or co-infections.

206. **Acute Hepatitis B Diagnosis Date** (recommended)
- Enter the date of the diagnosis.
207. **Chronic Hepatitis B Diagnosis Date** (recommended)
- Enter the date of the diagnosis.
208. **Acute Hepatitis C Diagnosis Date** (recommended)
- Enter the date of the diagnosis.
209. **Chronic Hepatitis C Diagnosis Date** (recommended)
- Enter the date of the diagnosis.

XII. Comments

This section is used to provide information that did not fit in the spaces provided or to add any other information that may be relevant to the client's case.

210. Comments (recommended)

- This space is used to record other information that may be pertinent to the case and the public health mission.

Section 3: The District of Columbia Department of Health Pediatric HIV Confidential Local Fields Form (Clients <13 years of age at time of diagnosis)

The District of Columbia Department of Health Pediatric HIV Confidential Local Fields Form is used to collect other information of that may be useful for public health purposes (Appendix B). Other fields included are for monitoring and evaluating DOH employee investigation processes. This form will be filled out by PHA's upon completion of a case investigation.

1. **Data Entry Person** (required)
 - Select the name of the data entry clerk.
 - a. **Volta Asbury**
 - b. **Deontrinese Henderson**
 - c. **Sabaina Lofinmakin**
 - d. **Paul Macarthy**
 - e. **Luckeya McCarroll**
 - f. **New Data Entry Clerk:** Provide data entry clerk's name.
2. **Prior to the client testing positive during recent testing event, was she/he previously reported to the jurisdiction's surveillance department as being HIV-positive?** (required)
 - Indicate if the client has been previously reported to the jurisdiction's surveillance department as being HIV-positive.
 - a. **Yes**
 - b. **No**
 - c. **Unknown:** Unable to determine if the client has been previously reported to the jurisdiction's surveillance department as being HIV-positive.
 - d. **Not Checked:** Department's staff has not checked to see if the client was previously reported to the jurisdiction's surveillance department as being HIV-positive.

Other Investigation Information

3. **PHA Initials** (required)
 - Select the initials identifying the field investigator who verified the information on the Case Report Form.
 - a. **DEE:** Deontrinese Henderson
 - b. **LAM:** Luckeya McCarroll
 - c. **PIM:** Paul Macarthy
 - d. **SOL:** Sabaina Lofinmakin
 - e. **VEA:** Volta Asbury
 - f. **New PHA:** Provide the new PHA's name
4. **Date Assigned to PHA** (required)
 - PHA should enter the date that the case was provided for investigation.
5. **Date PHA Closed Investigation** (required)
 - PHA should enter the date he/she has completed the investigation.
6. **Date PHA Turned-in Form** (required)
 - Supervisor to enter the date he/she has received the form for counting.
7. **Date of Record Search** (recommended)
 - PHA should enter the date he/she conducted a record search on the case.

8. **Type of record** (required)
 - PHA should indicate if the case is new or not.
 - a. **New:** The case does not exist in eHARS or a change in disease status.
 - b. **Update:** New information to add to an existing case in eHARS.
9. **District Ward Number** (recommended)
 - The Ward designation for where the client resides.
 - a. **Ward 1**
 - b. **Ward 2**
 - c. **Ward 3**
 - d. **Ward 4**
 - e. **Ward 5**
 - f. **Ward 6**
 - g. **Ward 7**
 - h. **Ward 8**
 - i. **Homeless (77)**
 - j. **Corrections (88)**
 - k. **Non-DC**
 - l. **Unknown**
10. **RIDR State Disposition** (required)
 - If case was part of the RIDR resolution list, please indicate the designated outcome.
 - a. **Same as:** The case was the same as the other jurisdiction's case.
 - b. **Different than:** The case was not the same as the other jurisdiction's case.

Comments

11. **PHA Comments** (recommended)
 - This space is used to record other information that may be pertinent to the case and the public health mission.
12. **HEALTH DEPARTMENT USE ONLY: STD MIS Field Record Number** (required)
 - If a Field Record was created, record the Field Record Number.

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Appendix A: Pediatric Case Report Form



DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
PEDIATRIC HIV CONFIDENTIAL CASE REPORT FORM
(Clients <13 years of age at time of diagnosis)

I. Health Department Use Only (record all dates as mm/dd/yyyy)
1. Date Rec'd at Health Department:
2. Document Source:
3. State No.:
4. Did this report initiate a new case investigation?
5. Report Medium
6. Surveillance Method

II. Facility Providing Information
7. Date Form Completed:
*8. Medical Record Number:
*9. Person Completing Form:
*10. Phone Number:
11. Facility Name:
12. Facility ID:
*13. Phone:
*14. Street Address:
15. City:
16. County/*Ward:
17. State/Country:
*18. ZIP Code:
19. Facility Type

III. Client Identification
*Client Name:
20. First Name
21. Middle Name
22. Last Name
*Alternate Name:
23. First Name
24. Middle Name
25. Last Name
*26. Phone
27. Address Type:
*28. Current Street Address
29. City
30. County/*Ward
31. State/Country
*32. ZIP Code
*33. Social Security Number
*34. Other ID
*34a. Other ID Number

IV. Client Demographics (record all dates as mm/dd/yyyy, type numbers only & include leading zeroes)
35. Diagnostic Status at Report:
36. Sex assigned at birth:
37. Date of Birth:
38. Alias Date of Birth:
39. Country of Birth:
40. Vital Status:
41. Date of Death:
42. State of Death:
43. Date of Last Medical Evaluation:
44. Date of Initial Evaluation for HIV:
45. Ethnicity
*46. Expanded Ethnicity
47. Race
*48. Expanded Race

V. Residence at Diagnosis (add additional addresses in Comments)
49. Address Type:
*50. Street Address:
51. City:
52. County/*Ward:
53. State/Country:
*54. ZIP Code:

VI. Facility of Diagnosis
55. Diagnosis Type
56. Facility Name:
*57. Phone:
*58. Street Address:
59. City:
60. County/*Ward:
61. State/Country:
*62. ZIP Code:
63. Facility Type
*64. Provider Name:
*65. Provider Phone:
*66. Specialty:

Client name:

VII. Client History (respond to all questions) (record all dates as mm/dd/yyyy, type numbers only & include leading zeroes)

67. 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

68. Date of mother's first positive HIV confirmatory test: _____ **69. 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, the client's biological mother had...

70. Perinatally acquired HIV infection Yes No Unknown

71. Used injected non-prescription drugs Yes No Unknown

<p>72. Vaginal sex with male <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 72a - 72f about mother's partner(s). If No or Unknown, go to 73</p>	<p>72a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>72d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>72f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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<p>73. Anal sex with male <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 73a - 73f about mother's partner(s). If No or Unknown, go to 74</p>	<p>73a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>73d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>73f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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<p>74. Vaginal sex with a transgendered individual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 74a - 74f about mother's partner(s). If No or Unknown, go to 75</p>	<p>74a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>74d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>74f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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<p>75. Anal sex with a transgendered individual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, answer 75a - 75f about mother's partner(s). If No or Unknown, go to 76</p>	<p>75a. Without using a condom <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>75b. Who is an IDU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>75c. Who is HIV + <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>75d. With hemophilia/coagulation disorder with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>75e. With transfusion recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>75f. With transplant recipient with documented HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
---	---	---

76. Vaginal sex with an MSM Yes No Unknown **77. Anal sex with an MSM** Yes No Unknown

78. Received transfusion of blood/blood components (other than clotting factor) Yes No Unknown (document reason in Comments section)
78a. If yes, first date received: _____ **78b. If yes, last date received:** _____

79. Received transplant of tissue/organs or artificial insemination Yes No Unknown

Before the diagnosis of HIV infection, this child had:

80. Injected non-prescription drugs Yes No Unknown

81. Received clotting factor for hemophilia/coagulation disorder: Yes No Unknown

81a. If yes, specify clotting factor: _____ **81b. If yes, date received:** _____

82. Received transfusion of blood/blood components (other than clotting factor): Yes No Unknown

82a. If yes, first date received: _____ **82b. If yes, last date received:** _____

83. Received transplant of tissue/organs Yes No Unknown

84. Sexual contact with male Yes No Unknown

85. Sexual contact with female Yes No Unknown

86. Other documented risk (please include detail in Comments section) Yes No Unknown

HEALTH DEPARTMENT USE ONLY

87. Is this an NIR/NRR case? Yes No Unknown **87a. If No Risk Reported, indicate date investigation was complete:** _____

Client name:

VIII. Laboratory Data (record additional tests in Comments section)

HIV Antibody Tests at Diagnosis (non-type differentiating)

Test 1 88. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 89. Result: Positive/Reactive Negative/Nonreactive Indeterminate 90. Rapid Test (check if rapid)
 91. Collection Date: _____ 92. Accession #: _____ 93. Manufacturer: _____

Test 2 94. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 95. Result: Positive/Reactive Negative/Nonreactive Indeterminate 96. Rapid Test (check if rapid)
 97. Collection Date: _____ 98. Accession #: _____ 99. Manufacturer: _____

Test 3 100. Type: HIV-1 EIA HIV-1/2 EIA HIV- 1/2 Ag/Ab HIV-1 WB HIV-1 IFA HIV-2 EIA HIV-2 WB Other: Specify Test: _____
 101. Result: Positive/Reactive Negative/Nonreactive Indeterminate 102. Rapid Test (check if rapid)
 103. Collection Date: _____ 104. Accession #: _____ 105. Manufacturer: _____

HIV Antibody Tests at Diagnosis (type differentiating)

Test 106. Type: HIV-1/2 Differentiating (e.g., Multispot)
 107. Result: HIV-1 HIV-2 Both (undifferentiated) Neither (negative)
 108. Collection Date: _____ 109. Accession #: _____

HIV Antibody Detection Tests

Test 1 110. Type: HIV-1 p24 Antigen HIV-1 RNA/DNA NAAT (Qual) HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture
 111. Result: Positive/Reactive Negative/Nonreactive Indeterminate 112. Collection date: _____ 113. Accession #: _____

Test 2 114. Type: HIV-1 p24 Antigen HIV-1 RNA/DNA NAAT (Qual) HIV-1 Culture HIV-2 RNA/DNA NAAT (Qual) HIV-2 Culture
 115. Result: Positive/Reactive Negative/Nonreactive Indeterminate 116. Collection date: _____ 117. Accession #: _____

Immunologic Lab Tests

At or closest to current diagnosis status: First <200 µL or <14%:
 118. CD4 count _____ cells/µL 122. CD4 count _____ cells/µL
 119. CD4 count _____ % 123. CD4 count _____ %
 120. Collection Date: _____ 124. Collection Date: _____
 121. Accession #: _____ 125. Accession #: _____

Viral Load Tests (include earliest detectable test after diagnosis)

Test 1 126. Result 127. Copies/ µL _____ 129. Collection Date: _____
 HIV-1 Detectable 128. Log _____ 130. Accession #: _____
 RNA VL Undetectable

Test 2 131. Result 132. Copies/ µL _____ 134. Collection Date: _____
 HIV-1 Detectable 133. Log _____ 135. Accession #: _____
 RNA VL Undetectable

136. Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? Yes No Unknown

136a. If YES, provide date (specimen collection date if known) of earliest positive test for this algorithm: _____

If HIV laboratory tests were not documented, is the client confirmed by a physician as:

137. HIV- Not Infected Yes No Unknown 137a. HIV-Infected Yes No Unknown

137b. If YES to either #137 or #137a, provide date of documentation by Physician: _____

138. Genotyping Date:

139. Phenotyping Date:

IX. Clinical (select D for Definitive or P for Presumptive where applicable)

	D	P	Date		D	P	Date		D	P	Date
140. Bacterial infection, multiple or recurrent (including Salmonella septicemia)	<input type="checkbox"/>			148. HIV encephalopathy	<input type="checkbox"/>			156. Lymphoma, primary in brain	<input type="checkbox"/>		
141. Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/>			149. Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis	<input type="checkbox"/>			157. Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
142. Candidiasis, esophageal	<input type="checkbox"/>	<input type="checkbox"/>		150. Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/>			158. M. tuberculosis, disseminated or extrapulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	
143. Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/>			151. Isosporiasis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>			159. Mycobacterium, of other/undifferentiated species, disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
144. Cryptococcosis, extrapulmonary	<input type="checkbox"/>			152. Kaposi's sarcoma	<input type="checkbox"/>	<input type="checkbox"/>		160. Pneumocystis pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
145. Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>			153. Lymphoid interstitial pneumonia and/or pulmonary lymphoid	<input type="checkbox"/>	<input type="checkbox"/>		161. Progressive multifocal leukoencephalopathy	<input type="checkbox"/>		
146. Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/>			154. Lymphoma, Burkitt's (or equivalent)	<input type="checkbox"/>			162. Toxoplasmosis of brain, onset at >1 mo. of age	<input type="checkbox"/>	<input type="checkbox"/>	
147. Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>		155. Lymphoma, immunoblastic (or equivalent)	<input type="checkbox"/>			163. Wasting syndrome due to HIV	<input type="checkbox"/>		
164. Has this child been diagnosed with pulmonary tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				164a. If yes, <input type="checkbox"/> Definitive <input type="checkbox"/> Presumptive <input type="checkbox"/> Unknown				164b. Date:	164c. If TB selected above, indicate RVCT Case Number:		

Client name:

X. Birth History (for Perinatal Cases Only)165. Birth History Available? Yes No UnknownResidence at Birth Check if SAME as current address

*166. Street Address:

167. City: 168. County/*Ward: 169. State/Country: *170. Zip Code:

Hospital of Birth

171. Facility Name: *172. Phone:

*173. Street Address:

174. City: 175. County/*Ward: 176. State/Country: *177. Zip Code:

Birth History178. Birth weight: lbs oz 179. Birth Type: Single Twin >2 Unknown 180. Delivery: Vaginal Elective Cesarean Non-Elective Cesarean Cesarean, unknown type Unknown181. Birth Defects: Yes No Unknown 181a. If yes, please specify:182. Neonatal Status: Full-term Premature Unknown 183. Neonatal Status Weeks:

184. Prenatal Care- Month of pregnancy prenatal care began: 184a. Prenatal Care- Total number of prenatal care visits:

185. Did mother receive zidovudine (ZDV, AZT) during pregnancy? Yes No Unknown 185a. If yes, what week of pregnancy was zidovudine (ZDV,AZT) started?186. Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Yes No Unknown 187. Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes No Unknown188. Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unknown 188a. If yes, please specify:189. Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unknown 189a. If yes, please specify:**Maternal Information**

190. Maternal DOB: 191. Maternal Soundex/Name: 192. Maternal State No: 193. Maternal Country of Birth:

*194. Other maternal ID-List Type: 195. Number:

XI. Treatment/Services Referrals**The child received or is receiving:**196. Neonatal zidovudine (ZDV, AZT) for HIV Prevention: Yes No Unknown 196a. If yes, date received: _____197. Other neonatal anti-retroviral medication for HIV Prevention: Yes No Unknown 197a. If yes, date received: _____
197b. If yes, please specify medication (refer to reference page 5):198. Anti-retroviral therapy for HIV treatment: Yes No Unknown 198a. If yes, date received: _____199. PCP Prophylaxis: Yes No Unknown 199a. If yes, date received: _____**Other Information**200. Was this child breastfed? Yes No Unknown201. This patient has been enrolled at: Clinical Trial (specify in comment section) Clinic (specify in comment section)

202. At time of HIV diagnosis, medical treatment primarily reimbursed by: (See reference sheet on page 6) 203. At time of AIDS diagnosis, medical treatment primarily reimbursed by: (See reference sheet on page 6)

204. Is the client receiving any of the following treatment reimbursements? ADAP Alliance Medicare205. This child's primary caretaker is: Biological parent Other relative Foster/Adoptive parent, relative Foster/Adoptive parent, unrelated
 Social Service Agency Other (specify in comments section) Unknown**Co-infections**

206. Acute Hepatitis B Dx Date: 207. Chronic Hepatitis B Dx Date:

208. Acute Hepatitis C Dx Date: 209. Chronic Hepatitis C Dx Date:

***XII. Provider Comments**

210.



**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
Pediatric HIV CONFIDENTIAL CASE REPORT FORM**

Reference Page

Question	Options			
19. and 63. Facility Type	<u>Inpatient:</u> <ul style="list-style-type: none"> • Hospital • Other, specify 	<u>Outpatient:</u> <ul style="list-style-type: none"> • Private Physician Office • Adult HIV Clinic • Other, specify 	<u>Screening, Diagnostic, Referral Agency:</u> <ul style="list-style-type: none"> • CTS • STD Clinic • Other, specify 	<u>Other Facility:</u> <ul style="list-style-type: none"> • Emergency Room • Laboratory • Corrections • Unknown • Other, specify
202. At time of HIV diagnosis, medical treatment primarily reimbursed by:	<ul style="list-style-type: none"> • CHAMPUS/TRICARE • Children’s Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO 	<ul style="list-style-type: none"> • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other 		<ul style="list-style-type: none"> • State Funded, Unspecified • Veterans Administration • No Health Insurance • Other • Unknown
203. At time of AIDS diagnosis, medical treatment primarily reimbursed by:	<ul style="list-style-type: none"> • CHAMPUS/TRICARE • Children’s Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO 	<ul style="list-style-type: none"> • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other 		<ul style="list-style-type: none"> • State Funded, Unspecified • Veterans Administration • No Health Insurance • Other • Unknown
197b. If Yes, list ARV Medications:	<ul style="list-style-type: none"> • Agenerase (amprenavir) • Aptivus (tipranavir,TPV) • Atripla (efavirenz/emtricitabine/tenofovir DF) • Combivir (lamivudine/zidovudine, 3TC/AZT) • Complera (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TDF) • Crixivan (indinavir, IDV) • Edurant (rilpivirine, RPV) • Emtriva (emtricitabine, FTC) • Eпивir (lamivudine, 3TC) • Epzicom (abacavir/lamivudine, ABD/3TC) • Fortovase (saquinavir, SQV) • Fuzeon (enfuvirtide, T20) • Hepsera (adefovir) • Hivid (zalcitabine, ddC) • Hydroxyurea • Intelence (etravirine) • Invirase (saquinavir, SQV) • Isentress (raltegravir) • Kaletra (lopinavir, ritonavir) • Lexiva (fosamprenavir, 908) 			<ul style="list-style-type: none"> • Norvir (ritonavir, RTV) • Prezista (darunavir, DRV) • Rescriptor (delavirdine, DLV) • Retrovir (zidovudine, ZDV, AZT) • Reyataz (atazanavir, ATV) • Saquinavir (fortavase, invirase) • Selzentry (maraviroc) • Sustiva (efavirenz, EFV) • Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) • Truvada (tenofovir DF/emtricitabine, TDF/FTC) • Videx (didanosine, ddl) • Videx EC (didanosine, ddl) • Viracept (nelfinavir, NFV) • Viramune (nevirapine, NVP) • Viread (tenofovir DF, TDF) • Zerit (stavudine, d4T) • Ziagen (abacavir, ABC) • Other • Unspecified

Please print a completed copy, place into a double-sealed envelope, marked "CONFIDENTIAL," and mail or hand deliver to the address provided at the bottom of this page. You may also contact the DOH Field Investigator assigned to your site from the HIV/AIDS, Hepatitis, STD and TB Administration to retrieve the completed documents. The Field Investigator may review the documents for completeness and accuracy against the patient’s medical charts. Any deficiencies will require the Field Investigator to obtain missing or discrepant information via telephone, in-person interview, chart abstraction or other methods deemed appropriate. It is not acceptable to FAX or e-mail a form with client information on it. Chapter 22 of The District of Columbia Municipal Regulations contains information on the reporting requirements for communicable diseases with a specific section for HIV. All Human Immunodeficiency Virus (HIV) infection cases (including Acquired Immune Deficiency Syndrome (AIDS)) shall be reported to the Director of the Department of Health or his or her designee. Physicians and others licensed to practice in the District under the District of Columbia Health Occupations Revision Act of 1985 (D.C. Official Code § 3-1201.01 et seq.), in charge of an AIDS diagnosis, shall report the AIDS diagnosis to the Director within forty-eight (48) hours of diagnosis and furnish information the Director deems necessary to complete a confidential case report. Additionally, physicians and others licensed under the District of Columbia Health Occupations Revision Act of 1985 shall report a HIV positive test result to the Director or his or her designee. The physician or provider, laboratory, blood bank, or other entity or facility that provides HIV testing shall report all cases of HIV infection to the Director or his or her designee.

Appendix B: Pediatric Local Fields Form



**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
PEDIATRIC HIV CONFIDENTIAL CASE REPORT FORM**

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

Local Fields – Health Department Use Only

1. Data Entry Person Volta Asbury Deontrinese Henderson Sabaina Lofinmakin Paul Macarthy Luckeya McCarroll
 New Data Entry Clerk (specify):

2. Prior to the client testing positive during recent testing event, was she/he previously reported to the jurisdiction’s surveillance department as being HIV-positive? Yes No Unknown Not Checked

Other Investigation Information

3. PHA Initials DEE LAM PIM SOL VEA New PHA (specify):

4. Date Assigned to PHA:

5. Date PHA Closed Investigation:

6. Date PHA Turned-in Form:

7. Date of Record Search:

8. Type of record: New Update

9. District Ward Number Ward 1 Ward 2 Ward 3 Ward 4 Homeless (77) Corrections (88) non-DC Unknown
 Ward 5 Ward 6 Ward 7 Ward 8

10. RIDR State Disposition Same as Different than

PHA Comments

11.

12. HEALTH DEPARTMENT USE ONLY: STD MIS Field Record Number

Appendix C: Race Concepts

Race Concepts for American Indian or Alaska Native

Unique Identifier	Hierarchical Code	Concept
1002-5	R1	American Indian or Alaska Native
1004-1	R1.01	American Indian
1006-6	R1.01.001	Abenaki
1008-2	R1.01.002	Algonquian
1010-8	R1.01.003	Apache
1011-6	R1.01.003.001	Chiricahua
1012-4	R1.01.003.002	Fort Sill Apache
1013-2	R1.01.003.003	Jicarilla Apache
1014-0	R1.01.003.004	Lipan Apache
1015-7	R1.01.003.005	Mescalero Apache
1016-5	R1.01.003.006	Oklahoma Apache
1017-3	R1.01.003.007	Payson Apache
1018-1	R1.01.003.008	San Carlos Apache
1019-9	R1.01.003.009	White Mountain Apache
1021-5	R1.01.004	Arapaho
1022-3	R1.01.004.001	Northern Arapaho
1023-1	R1.01.004.002	Southern Arapaho
1024-9	R1.01.004.003	Wind River Arapaho
1026-4	R1.01.005	Arikara
1028-0	R1.01.006	Assiniboine
1030-6	R1.01.007	Assiniboine Sioux
1031-4	R1.01.007.001	Fort Peck Assiniboine Sioux
1033-0	R1.01.008	Bannock
1035-5	R1.01.009	Blackfeet
1037-1	R1.01.010	Brotherton
1039-7	R1.01.011	Burt Lake Band
1041-3	R1.01.012	Caddo
1042-1	R1.01.012.001	Oklahoma Cado
1044-7	R1.01.013	Cahuilla
1045-4	R1.01.013.001	Agua Caliente Cahuilla
1046-2	R1.01.013.002	Augustine
1047-0	R1.01.013.003	Cabazon
1048-8	R1.01.013.004	Los Coyotes
1049-6	R1.01.013.005	Morongo
1050-4	R1.01.013.006	Santa Rosa Cahuilla
1051-2	R1.01.013.007	Torres-Martinez
1053-8	R1.01.014	California Tribes
1054-6	R1.01.014.001	Cahto
1055-3	R1.01.014.002	Chimariko
1056-1	R1.01.014.003	Coast Miwok
1057-9	R1.01.014.004	Digger
1058-7	R1.01.014.005	Kawaiisu
1059-5	R1.01.014.006	Kern River
1060-3	R1.01.014.007	Mattole
1061-1	R1.01.014.008	Red Wood
1062-9	R1.01.014.009	Santa Rosa
1063-7	R1.01.014.010	Takelma
1064-5	R1.01.014.011	Wappo
1065-2	R1.01.014.012	Yana
1066-0	R1.01.014.013	Yuki
1068-6	R1.01.015	Canadian and Latin American Indian
1069-4	R1.01.015.001	Canadian Indian
1070-2	R1.01.015.002	Central American Indian
1071-0	R1.01.015.003	French American Indian
1072-8	R1.01.015.004	Mexican American Indian
1073-6	R1.01.015.005	South American Indian
1074-4	R1.01.015.006	Spanish American Indian
1076-9	R1.01.016	Catawba
1078-5	R1.01.017	Cayuse

1080-1	R1.01.018	Chehalis
1082-7	R1.01.019	Chemakuan
1083-5	R1.01.019.001	Hoh
1084-3	R1.01.019.002	Quileute
1086-8	R1.01.020	Chemehuevi
1088-4	R1.01.021	Cherokee
1089-2	R1.01.021.001	Cherokee Alabama
1090-0	R1.01.021.002	Cherokees of Northeast Alabama
1091-8	R1.01.021.003	Cherokees of Southeast Alabama
1092-6	R1.01.021.004	Eastern Cherokee
1093-4	R1.01.021.005	Echota Cherokee
1094-2	R1.01.021.006	Etowah Cherokee
1095-9	R1.01.021.007	Northern Cherokee
1096-7	R1.01.021.008	Tuscola
1097-5	R1.01.021.009	United Keetowah Band of Cherokee
1098-3	R1.01.021.010	Western Cherokee
1100-7	R1.01.022	Cherokee Shawnee
1102-3	R1.01.023	Cheyenne
1103-1	R1.01.023.001	Northern Cheyenne
1104-9	R1.01.023.002	Southern Cheyenne
1106-4	R1.01.024	Cheyenne-Arapaho
1108-0	R1.01.025	Chickahominy
1109-8	R1.01.025.001	Eastern Chickahominy
1110-6	R1.01.025.002	Western Chickahominy
1112-2	R1.01.026	Chickasaw
1114-8	R1.01.027	Chinook
1115-5	R1.01.027.001	Clatsop
1116-3	R1.01.027.002	Columbia River Chinook
1117-1	R1.01.027.003	Kathlamet
1118-9	R1.01.027.004	Upper Chinook
1119-7	R1.01.027.005	Wakiakum Chinook
1120-5	R1.01.027.006	Willapa Chinook
1121-3	R1.01.027.007	Wishram
1123-9	R1.01.028	Chippewa
1124-7	R1.01.028.001	Bad River
1125-4	R1.01.028.002	Bay Mills Chippewa
1126-2	R1.01.028.003	Bois Forte
1127-0	R1.01.028.004	Burt Lake Chippewa
1128-8	R1.01.028.005	Fond du Lac
1129-6	R1.01.028.006	Grand Portage
1130-4	R1.01.028.007	Grand Traverse Band of Ottawa/Chippewa
1131-2	R1.01.028.008	Keweenaw
1132-0	R1.01.028.009	Lac Courte Oreilles
1133-8	R1.01.028.010	Lac du Flambeau
1134-6	R1.01.028.011	Lac Vieux Desert Chippewa
1135-3	R1.01.028.012	Lake Superior
1136-1	R1.01.028.013	Leech Lake
1137-9	R1.01.028.014	Little Shell Chippewa
1138-7	R1.01.028.015	Mille Lacs
1139-5	R1.01.028.016	Minnesota Chippewa
1140-3	R1.01.028.017	Ontonagon
1141-1	R1.01.028.018	Red Cliff Chippewa
1142-9	R1.01.028.019	Red Lake Chippewa
1143-7	R1.01.028.020	Saginaw Chippewa
1144-5	R1.01.028.021	St. Croix Chippewa
1145-2	R1.01.028.022	Sault Ste. Marie Chippewa
1146-0	R1.01.028.023	Sokoagon Chippewa
1147-8	R1.01.028.024	Turtle Mountain
1148-6	R1.01.028.025	White Earth
1150-2	R1.01.029	Chippewa Cree
1151-0	R1.01.029.001	Rocky Boy's Chippewa Cree
1153-6	R1.01.030	Chitimacha
1155-1	R1.01.031	Choctaw

1156-9	R1.01.031.001	Clifton Choctaw
1157-7	R1.01.031.002	Jena Choctaw
1158-5	R1.01.031.003	Mississippi Choctaw
1159-3	R1.01.031.004	Mowa Band of Choctaw
1160-1	R1.01.031.005	Oklahoma Choctaw
1162-7	R1.01.032	Chumash
1163-5	R1.01.032.001	Santa Ynez
1165-0	R1.01.033	Clear Lake
1167-6	R1.01.034	Coeur D'Alene
1169-2	R1.01.035	Coharie
1171-8	R1.01.036	Colorado River
1173-4	R1.01.037	Colville
1175-9	R1.01.038	Comanche
1176-7	R1.01.038.001	Oklahoma Comanche
1178-3	R1.01.039	Coos, Lower Umpqua, Siuslaw
1180-9	R1.01.040	Coos
1182-5	R1.01.041	Coquilles
1184-1	R1.01.042	Costanoan
1186-6	R1.01.043	Coushatta
1187-4	R1.01.043.001	Alabama Coushatta
1189-0	R1.01.044	Cowlitz
1191-6	R1.01.045	Cree
1193-2	R1.01.046	Creek
1194-0	R1.01.046.001	Alabama Creek
1195-7	R1.01.046.002	Alabama Quassarte
1196-5	R1.01.046.003	Eastern Creek
1197-3	R1.01.046.004	Eastern Muscogee
1198-1	R1.01.046.005	Kialegee
1199-9	R1.01.046.006	Lower Muscogee
1200-5	R1.01.046.007	Machis Lower Creek Indian
1201-3	R1.01.046.008	Poarch Band
1202-1	R1.01.046.009	Principal Creek Indian Nation
1203-9	R1.01.046.010	Star Clan of Muscogee Creeks
1204-7	R1.01.046.011	Thlopthlocco
1205-4	R1.01.046.012	Tuckabachee
1207-0	R1.01.047	Croatan
1209-6	R1.01.048	Crow
1211-2	R1.01.049	Cupeno
1212-0	R1.01.049.001	Agua Caliente
1214-6	R1.01.050	Delaware
1215-3	R1.01.050.001	Eastern Delaware
1216-1	R1.01.050.002	Lenni-Lenape
1217-9	R1.01.050.003	Munsee
1218-7	R1.01.050.004	Oklahoma Delaware
1219-5	R1.01.050.005	Rampough Mountain
1220-3	R1.01.050.006	Sand Hill
1222-9	R1.01.051	Diegueno
1223-7	R1.01.051.001	Campo
1224-5	R1.01.051.002	Capitan Grande
1225-2	R1.01.051.003	Cuyapaibe
1226-0	R1.01.051.004	La Posta
1227-8	R1.01.051.005	Manzanita
1228-6	R1.01.051.006	Mesa Grande
1229-4	R1.01.051.007	San Pasqual
1230-2	R1.01.051.008	Santa Ysabel
1231-0	R1.01.051.009	Sycuan
1233-6	R1.01.052	Eastern Tribes
1234-4	R1.01.052.001	Attacapa
1235-1	R1.01.052.002	Biloxi
1236-9	R1.01.052.003	Georgetown
1237-7	R1.01.052.004	Moor
1238-5	R1.01.052.005	Nansemond
1239-3	R1.01.052.006	Natchez

1240-1	R1.01.052.007	Nausu Waiwash
1241-9	R1.01.052.008	Nipmuc
1242-7	R1.01.052.009	Paugussett
1243-5	R1.01.052.010	Pocomoke Acohonock
1244-3	R1.01.052.011	Southeastern Indians
1245-0	R1.01.052.012	Susquehanock
1246-8	R1.01.052.013	Tunica Biloxi
1247-6	R1.01.052.014	Waccamaw-Siousan
1248-4	R1.01.052.015	Wicomico
1250-0	R1.01.053	Esselen
1252-6	R1.01.054	Fort Belknap
1254-2	R1.01.055	Fort Berthold
1256-7	R1.01.056	Fort Mcdowell
1258-3	R1.01.057	Fort Hall
1260-9	R1.01.058	Gabrieleno
1262-5	R1.01.059	Grand Ronde
1264-1	R1.01.060	Gros Ventres
1265-8	R1.01.060.001	Atsina
1267-4	R1.01.061	Haliwa
1269-0	R1.01.062	Hidatsa
1271-6	R1.01.063	Hoopa
1272-4	R1.01.063.001	Trinity
1273-2	R1.01.063.002	Whilkut
1275-7	R1.01.064	Hoopa Extension
1277-3	R1.01.065	Houma
1279-9	R1.01.066	Inaja-Cosmit
1281-5	R1.01.067	Iowa
1282-3	R1.01.067.001	Iowa of Kansas-Nebraska
1283-1	R1.01.067.002	Iowa of Oklahoma
1285-6	R1.01.068	Iroquois
1286-4	R1.01.068.001	Cayuga
1287-2	R1.01.068.002	Mohawk
1288-0	R1.01.068.003	Oneida
1289-8	R1.01.068.004	Onondaga
1290-6	R1.01.068.005	Seneca
1291-4	R1.01.068.006	Seneca Nation
1292-2	R1.01.068.007	Seneca-Cayuga
1293-0	R1.01.068.008	Tonawanda Seneca
1294-8	R1.01.068.009	Tuscarora
1295-5	R1.01.068.010	Wyandotte
1297-1	R1.01.069	Juaneno
1299-7	R1.01.070	Kalispel
1301-1	R1.01.071	Karuk
1303-7	R1.01.072	Kaw
1305-2	R1.01.073	Kickapoo
1306-0	R1.01.073.001	Oklahoma Kickapoo
1307-8	R1.01.073.002	Texas Kickapoo
1309-4	R1.01.074	Kiowa
1310-2	R1.01.074.001	Oklahoma Kiowa
1312-8	R1.01.075	Klallam
1313-6	R1.01.075.001	Jamestown
1314-4	R1.01.075.002	Lower Elwha
1315-1	R1.01.075.003	Port Gamble Klallam
1317-7	R1.01.076	Klamath
1319-3	R1.01.077	Konkow
1321-9	R1.01.078	Kootenai
1323-5	R1.01.079	Lassik
1325-0	R1.01.080	Long Island
1326-8	R1.01.080.001	Matinecock
1327-6	R1.01.080.002	Montauk
1328-4	R1.01.080.003	Poospatuck
1329-2	R1.01.080.004	Setauket

1331-8	R1.01.081	Luiseno
1332-6	R1.01.081.001	La Jolla
1333-4	R1.01.081.002	Pala
1334-2	R1.01.081.003	Pauma
1335-9	R1.01.081.004	Pechanga
1336-7	R1.01.081.005	Soboba
1337-5	R1.01.081.006	Twenty-Nine Palms
1338-3	R1.01.081.007	Temecula
1340-9	R1.01.082	Lumbee
1342-5	R1.01.083	Lummi
1344-1	R1.01.084	Maidu
1345-8	R1.01.084.001	Mountain Maidu
1346-6	R1.01.084.002	Nishinam
1348-2	R1.01.085	Makah
1350-8	R1.01.086	Maliseet
1352-4	R1.01.087	Mandan
1354-0	R1.01.088	Mattaponi
1356-5	R1.01.089	Menominee
1358-1	R1.01.090	Miami
1359-9	R1.01.090.001	Illinois Miami
1360-7	R1.01.090.002	Indiana Miami
1361-5	R1.01.090.003	Oklahoma Miami
1363-1	R1.01.091	Miccosukee
1365-6	R1.01.092	Micmac
1366-4	R1.01.092.001	Aroostook
1368-0	R1.01.093	Mission Indians
1370-6	R1.01.094	Miwok
1372-2	R1.01.095	Modoc
1374-8	R1.01.096	Mohegan
1376-3	R1.01.097	Mono
1378-9	R1.01.098	Nanticoke
1380-5	R1.01.099	Narragansett
1382-1	R1.01.100	Navajo
1383-9	R1.01.100.001	Alamo Navajo
1384-7	R1.01.100.002	Canoncito Navajo
1385-4	R1.01.100.003	Ramah Navajo
1387-0	R1.01.101	Nez Perce
1389-6	R1.01.102	Nomalaki
1391-2	R1.01.103	Northwest Tribes
1392-0	R1.01.103.001	Alsea
1393-8	R1.01.103.002	Celilo
1394-6	R1.01.103.003	Columbia
1395-3	R1.01.103.004	Kalapuya
1396-1	R1.01.103.005	Molala
1397-9	R1.01.103.006	Talakamish
1398-7	R1.01.103.007	Tenino
1399-5	R1.01.103.008	Tillamook
1400-1	R1.01.103.009	Wenatchee
1401-9	R1.01.103.010	Yahoeskin
1403-5	R1.01.104	Omaha
1405-0	R1.01.105	Oregon Athabaskan
1407-6	R1.01.106	Osage
1409-2	R1.01.107	Otoe-Missouria
1411-8	R1.01.108	Ottawa
1412-6	R1.01.108.001	Burt Lake Ottawa
1413-4	R1.01.108.002	Michigan Ottawa
1414-2	R1.01.108.003	Oklahoma Ottawa
1416-7	R1.01.109	Paiute
1417-5	R1.01.109.001	Bishop
1418-3	R1.01.109.002	Bridgeport
1419-1	R1.01.109.003	Burns Paiute
1420-9	R1.01.109.004	Cedarville

1421-7	R1.01.109.005	Fort Bidwell
1422-5	R1.01.109.006	Fort Independence
1423-3	R1.01.109.007	Kaibab
1424-1	R1.01.109.008	Las Vegas
1425-8	R1.01.109.009	Lone Pine
1426-6	R1.01.109.010	Lovelock
1427-4	R1.01.109.011	Malheur Paiute
1428-2	R1.01.109.012	Moapa
1429-0	R1.01.109.013	Northern Paiute
1430-8	R1.01.109.014	Owens Valley
1431-6	R1.01.109.015	Pyramid Lake
1432-4	R1.01.109.016	San Juan Southern Paiute
1433-2	R1.01.109.017	Southern Paiute
1434-0	R1.01.109.018	Summit Lake
1435-7	R1.01.109.019	Utu Utu Gwaitu Paiute
1436-5	R1.01.109.020	Walker River
1437-3	R1.01.109.021	Yerington Paiute
1439-9	R1.01.110	Pamunkey
1441-5	R1.01.111	Passamaquoddy
1442-3	R1.01.111.001	Indian Township
1443-1	R1.01.111.002	Pleasant Point Passamaquoddy
1445-6	R1.01.112	Pawnee
1446-4	R1.01.112.001	Oklahoma Pawnee
1448-0	R1.01.113	Penobscot
1450-6	R1.01.114	Peoria
1451-4	R1.01.114.001	Oklahoma Peoria
1453-0	R1.01.115	Pequot
1454-8	R1.01.115.001	Marshantucket Pequot
1456-3	R1.01.116	Pima
1457-1	R1.01.116.001	Gila River Pima-Maricopa
1458-9	R1.01.116.002	Salt River Pima-Maricopa
1460-5	R1.01.117	Piscataway
1462-1	R1.01.118	Pit River
1464-7	R1.01.119	Pomo
1465-4	R1.01.119.001	Central Pomo
1466-2	R1.01.119.002	Dry Creek
1467-0	R1.01.119.003	Eastern Pomo
1468-8	R1.01.119.004	Kashia
1469-6	R1.01.119.005	Northern Pomo
1470-4	R1.01.119.006	Scotts Valley
1471-2	R1.01.119.007	Stonyford
1472-0	R1.01.119.008	Sulphur Bank
1474-6	R1.01.120	Ponca
1475-3	R1.01.120.001	Nebraska Ponca
1476-1	R1.01.120.002	Oklahoma Ponca
1478-7	R1.01.121	Potawatomi
1479-5	R1.01.121.001	Citizen Band Potawatomi
1480-3	R1.01.121.002	Forest County
1481-1	R1.01.121.003	Hannahville
1482-9	R1.01.121.004	Huron Potawatomi
1483-7	R1.01.121.005	Pokagon Potawatomi
1484-5	R1.01.121.006	Prairie Band
1485-2	R1.01.121.007	Wisconsin Potawatomi
1487-8	R1.01.122	Powhatan
1489-4	R1.01.123	Pueblo
1490-2	R1.01.123.001	Acoma
1491-0	R1.01.123.002	Arizona Tewa
1492-8	R1.01.123.003	Cochiti
1493-6	R1.01.123.004	Hopi
1494-4	R1.01.123.005	Isleta
1495-1	R1.01.123.006	Jemez
1496-9	R1.01.123.007	Keres
1497-7	R1.01.123.008	Laguna

1498-5	R1.01.123.009	Nambe
1499-3	R1.01.123.010	Picuris
1500-8	R1.01.123.011	Piro
1501-6	R1.01.123.012	Pojoaque
1502-4	R1.01.123.013	San Felipe
1503-2	R1.01.123.014	San Ildefonso
1504-0	R1.01.123.015	San Juan Pueblo
1505-7	R1.01.123.016	San Juan De
1506-5	R1.01.123.017	San Juan
1507-3	R1.01.123.018	Sandia
1508-1	R1.01.123.019	Santa Ana
1509-9	R1.01.123.020	Santa Clara
1510-7	R1.01.123.021	Santo Domingo
1511-5	R1.01.123.022	Taos
1512-3	R1.01.123.023	Tesuque
1513-1	R1.01.123.024	Tewa
1514-9	R1.01.123.025	Tigua
1515-6	R1.01.123.026	Zia
1516-4	R1.01.123.027	Zuni
1518-0	R1.01.124	Puget Sound Salish
1519-8	R1.01.124.001	Duwamish
1520-6	R1.01.124.002	Kikiallus
1521-4	R1.01.124.003	Lower Skagit
1522-2	R1.01.124.004	Muckleshoot
1523-0	R1.01.124.005	Nisqually
1524-8	R1.01.124.006	Nooksack
1525-5	R1.01.124.007	Port Madison
1526-3	R1.01.124.008	Puyallup
1527-1	R1.01.124.009	Samish
1528-9	R1.01.124.010	Sauk-Suiattle
1529-7	R1.01.124.011	Skokomish
1530-5	R1.01.124.012	Skykomish
1531-3	R1.01.124.013	Snohomish
1532-1	R1.01.124.014	Snoqualmie
1533-9	R1.01.124.015	Squaxin Island
1534-7	R1.01.124.016	Steilacoom
1535-4	R1.01.124.017	Stillaguamish
1536-2	R1.01.124.018	Suquamish
1537-0	R1.01.124.019	Swinomish
1538-8	R1.01.124.020	Tulalip
1539-6	R1.01.124.021	Upper Skagit
1541-2	R1.01.125	Quapaw
1543-8	R1.01.126	Quinault
1545-3	R1.01.127	Rappahannock
1547-9	R1.01.128	Reno-Sparks
1549-5	R1.01.129	Round Valley
1551-1	R1.01.130	Sac and Fox
1552-9	R1.01.130.001	Iowa Sac and Fox
1553-7	R1.01.130.002	Missouri Sac and Fox
1554-5	R1.01.130.003	Oklahoma Sac and Fox
1556-0	R1.01.131	Salinan
1558-6	R1.01.132	Salish
1560-2	R1.01.133	Salish and Kootenai
1562-8	R1.01.134	Schaghticoke
1564-4	R1.01.135	Scott Valley
1566-9	R1.01.136	Seminole
1567-7	R1.01.136.001	Big Cypress
1568-5	R1.01.136.002	Brighton
1569-3	R1.01.136.003	Florida Seminole
1570-1	R1.01.136.004	Hollywood Seminole
1571-9	R1.01.136.005	Oklahoma Seminole
1573-5	R1.01.137	Serrano
1574-3	R1.01.137.001	San Manual

1576-8	R1.01.138	Shasta
1578-4	R1.01.139	Shawnee
1579-2	R1.01.139.001	Absentee Shawnee
1580-0	R1.01.139.002	Eastern Shawnee
1582-6	R1.01.140	Shinnecock
1584-2	R1.01.141	Shoalwater Bay
1586-7	R1.01.142	Shoshone
1587-5	R1.01.142.001	Battle Mountain
1588-3	R1.01.142.002	Duckwater
1589-1	R1.01.142.003	Elko
1590-9	R1.01.142.004	Ely
1591-7	R1.01.142.005	Goshute
1592-5	R1.01.142.006	Panamint
1593-3	R1.01.142.007	Ruby Valley
1594-1	R1.01.142.008	Skull Valley
1595-8	R1.01.142.009	South Fork Shoshone
1596-6	R1.01.142.010	Te-Moak Western Shoshone
1597-4	R1.01.142.011	Timbi-Sha Shoshone
1598-2	R1.01.142.012	Washakie
1599-0	R1.01.142.013	Wind River Shoshone
1600-6	R1.01.142.014	Yomba
1602-2	R1.01.143	Shoshone Paiute
1603-0	R1.01.143.001	Duck Valley
1604-8	R1.01.143.002	Fallon
1605-5	R1.01.143.003	Fort McDermitt
1607-1	R1.01.144	Siletz
1609-7	R1.01.145	Sioux
1610-5	R1.01.145.001	Blackfoot Sioux
1611-3	R1.01.145.002	Brule Sioux
1612-1	R1.01.145.003	Cheyenne River Sioux
1613-9	R1.01.145.004	Crow Creek Sioux
1614-7	R1.01.145.005	Dakota Sioux
1615-4	R1.01.145.006	Flandreau Santee
1616-2	R1.01.145.007	Fort Peck
1617-0	R1.01.145.008	Lake Traverse Sioux
1618-8	R1.01.145.009	Lower Brule Sioux
1619-6	R1.01.145.010	Lower Sioux
1620-4	R1.01.145.011	Mdewakanton Sioux
1621-2	R1.01.145.012	Miniconjou
1622-0	R1.01.145.013	Oglala Sioux
1623-8	R1.01.145.014	Pine Ridge Sioux
1624-6	R1.01.145.015	Pipestone Sioux
1625-3	R1.01.145.016	Prairie Island Sioux
1626-1	R1.01.145.017	Prior Lake Sioux
1627-9	R1.01.145.018	Rosebud Sioux
1628-7	R1.01.145.019	Sans Arc Sioux
1629-5	R1.01.145.020	Santee Sioux
1630-3	R1.01.145.021	Sisseton-Wahpeton
1631-1	R1.01.145.022	Sisseton Sioux
1632-9	R1.01.145.023	Spirit Lake Sioux
1633-7	R1.01.145.024	Standing Rock Sioux
1634-5	R1.01.145.025	Teton Sioux
1635-2	R1.01.145.026	Two Kettle Sioux
1636-0	R1.01.145.027	Upper Sioux
1637-8	R1.01.145.028	Wahpekute Sioux
1638-6	R1.01.145.029	Wahpeton Sioux
1639-4	R1.01.145.030	Wazhaza Sioux
1640-2	R1.01.145.031	Yankton Sioux
1641-0	R1.01.145.032	Yanktonai Sioux
1643-6	R1.01.146	Siuslaw
1645-1	R1.01.147	Spokane
1647-7	R1.01.148	Stewart
1649-3	R1.01.149	Stockbridge

1651-9	R1.01.150	Susanville
1653-5	R1.01.151	Tohono O'Odham
1654-3	R1.01.151.001	Ak-Chin
1655-0	R1.01.151.002	Gila Bend
1656-8	R1.01.151.003	San Xavier
1657-6	R1.01.151.004	Sells
1659-2	R1.01.152	Tolowa
1661-8	R1.01.153	Tonkawa
1663-4	R1.01.154	Tygh
1665-9	R1.01.155	Umatilla
1667-5	R1.01.156	Umpqua
1668-3	R1.01.156.001	Cow Creek Umpqua
1670-9	R1.01.157	Ute
1671-7	R1.01.157.001	Allen Canyon
1672-5	R1.01.157.002	Uintah Ute
1673-3	R1.01.157.003	Ute Mountain Ute
1675-8	R1.01.158	Wailaki
1677-4	R1.01.159	Walla-Walla
1679-0	R1.01.160	Wampanoag
1680-8	R1.01.160.001	Gay Head Wampanoag
1681-6	R1.01.160.002	Mashpee Wampanoag
1683-2	R1.01.161	Warm Springs
1685-7	R1.01.162	Wascopum
1687-3	R1.01.163	Washoe
1688-1	R1.01.163.001	Alpine
1689-9	R1.01.163.002	Carson
1690-7	R1.01.163.003	Dresslerville
1692-3	R1.01.164	Wichita
1694-9	R1.01.165	Wind River
1696-4	R1.01.166	Winnebago
1697-2	R1.01.166.001	Ho-chunk
1698-0	R1.01.166.002	Nebraska Winnebago
1700-4	R1.01.167	Winnemucca
1702-0	R1.01.168	Wintun
1704-6	R1.01.169	Wiyot
1705-3	R1.01.169.001	Table Bluff
1707-9	R1.01.170	Yakama
1709-5	R1.01.171	Yakama Cowlitz
1711-1	R1.01.172	Yaqui
1712-9	R1.01.172.001	Barrio Libre
1713-7	R1.01.172.002	Pascua Yaqui
1715-2	R1.01.173	Yavapai Apache
1717-8	R1.01.174	Yokuts
1718-6	R1.01.174.001	Chukchansi
1719-4	R1.01.174.002	Tachi
1720-2	R1.01.174.003	Tule River
1722-8	R1.01.175	Yuchi
1724-4	R1.01.176	Yuman
1725-1	R1.01.176.001	Cocopah
1726-9	R1.01.176.002	Havasupai
1727-7	R1.01.176.003	Hualapai
1728-5	R1.01.176.004	Maricopa
1729-3	R1.01.176.005	Mohave
1730-1	R1.01.176.006	Quechan
1731-9	R1.01.176.007	Yavapai
1732-7	R1.01.177	Yurok
1733-5	R1.01.177.001	Coast Yurok
1735-0	R1.02	Alaska Native
1737-6	R1.02.001	Alaska Indian
1739-2	R1.02.001.001	Alaskan Athabascan
1740-0	R1.02.001.001.001	Ahtna
1741-8	R1.02.001.001.002	Alatna

1742-6	R1.02.001.001.003	Alexander
1743-4	R1.02.001.001.004	Allakaket
1744-2	R1.02.001.001.005	Alanvik
1745-9	R1.02.001.001.006	Anvik
1746-7	R1.02.001.001.007	Arctic
1747-5	R1.02.001.001.008	Beaver
1748-3	R1.02.001.001.009	Birch Creek
1749-1	R1.02.001.001.010	Cantwell
1750-9	R1.02.001.001.011	Chalkyitsik
1751-7	R1.02.001.001.012	Chickaloon
1752-5	R1.02.001.001.013	Chistochina
1753-3	R1.02.001.001.014	Chitina
1754-1	R1.02.001.001.015	Circle
1755-8	R1.02.001.001.016	Cook Inlet
1756-6	R1.02.001.001.017	Copper Center
1757-4	R1.02.001.001.018	Copper River
1758-2	R1.02.001.001.019	Dot Lake
1759-0	R1.02.001.001.020	Doyon
1760-8	R1.02.001.001.021	Eagle
1761-6	R1.02.001.001.022	Eklutna
1762-4	R1.02.001.001.023	Evansville
1763-2	R1.02.001.001.024	Fort Yukon
1764-0	R1.02.001.001.025	Gakona
1765-7	R1.02.001.001.026	Galena
1766-5	R1.02.001.001.027	Grayling
1767-3	R1.02.001.001.028	Gulkana
1768-1	R1.02.001.001.029	Healy Lake
1769-9	R1.02.001.001.030	Holy Cross
1770-7	R1.02.001.001.031	Hughes
1771-5	R1.02.001.001.032	Huslia
1772-3	R1.02.001.001.033	Iliamna
1773-1	R1.02.001.001.034	Kaltag
1774-9	R1.02.001.001.035	Kluti Kaah
1775-6	R1.02.001.001.036	Knik
1776-4	R1.02.001.001.037	Koyukuk
1777-2	R1.02.001.001.038	Lake Minchumina
1778-0	R1.02.001.001.039	Lime
1779-8	R1.02.001.001.040	Mcgrath
1780-6	R1.02.001.001.041	Manley Hot Springs
1781-4	R1.02.001.001.042	Mentasta Lake
1782-2	R1.02.001.001.043	Minto
1783-0	R1.02.001.001.044	Nenana
1784-8	R1.02.001.001.045	Nikolai
1785-5	R1.02.001.001.046	Ninilchik
1786-3	R1.02.001.001.047	Nondalton
1787-1	R1.02.001.001.048	Northway
1788-9	R1.02.001.001.049	Nulato
1789-7	R1.02.001.001.050	Pedro Bay
1790-5	R1.02.001.001.051	Rampart
1791-3	R1.02.001.001.052	Ruby
1792-1	R1.02.001.001.053	Salamatof
1793-9	R1.02.001.001.054	Seldovia
1794-7	R1.02.001.001.055	Slana
1795-4	R1.02.001.001.056	Shageluk
1796-2	R1.02.001.001.057	Stevens
1797-0	R1.02.001.001.058	Stony River
1798-8	R1.02.001.001.059	Takotna
1799-6	R1.02.001.001.060	Tanacross
1800-2	R1.02.001.001.061	Tanaina
1801-0	R1.02.001.001.062	Tanana
1802-8	R1.02.001.001.063	Tanana Chiefs
1803-6	R1.02.001.001.064	Tazlina
1804-4	R1.02.001.001.065	Telida
1805-1	R1.02.001.001.066	Tetlin

1806-9	R1.02.001.001.067	Tok
1807-7	R1.02.001.001.068	Tyonek
1808-5	R1.02.001.001.069	Venetie
1809-3	R1.02.001.001.070	Wiseman
1811-9	R1.02.001.002	Southeast Alaska
1813-5	R1.02.001.002.001	Tlingit-Haida
1814-3	R1.02.001.002.001.001	Angoon
1815-0	R1.02.001.002.001.002	Central Council of Tlingit and Haida Tribes
1816-8	R1.02.001.002.001.003	Chilkat
1817-6	R1.02.001.002.001.004	Chilkoot
1818-4	R1.02.001.002.001.005	Craig
1819-2	R1.02.001.002.001.006	Douglas
1820-0	R1.02.001.002.001.007	Haida
1821-8	R1.02.001.002.001.008	Hoonah
1822-6	R1.02.001.002.001.009	Hydaburg
1823-4	R1.02.001.002.001.010	Kake
1824-2	R1.02.001.002.001.011	Kasaan
1825-9	R1.02.001.002.001.012	Kenaitze
1826-7	R1.02.001.002.001.013	Ketchikan
1827-5	R1.02.001.002.001.014	Klawock
1828-3	R1.02.001.002.001.015	Pelican
1829-1	R1.02.001.002.001.016	Petersburg
1830-9	R1.02.001.002.001.017	Saxman
1831-7	R1.02.001.002.001.018	Sitka
1832-5	R1.02.001.002.001.019	Tenakee Springs
1833-3	R1.02.001.002.001.020	Tlingit
1834-1	R1.02.001.002.001.021	Wrangell
1835-8	R1.02.001.002.001.022	Yakutat
1837-4	R1.02.001.002.002	Tsimshian
1838-2	R1.02.001.002.002.001	Metlakatla
1840-8	R1.02.002	Eskimo
1842-4	R1.02.002.001	Greenland Eskimo
1844-0	R1.02.002.002	Inupiat Eskimo
1845-7	R1.02.002.002.001	Ambler
1846-5	R1.02.002.002.002	Anaktuvuk
1847-3	R1.02.002.002.003	Anaktuvuk Pass
1848-1	R1.02.002.002.004	Arctic Slope Inupiat
1849-9	R1.02.002.002.005	Arctic Slope Corporation
1850-7	R1.02.002.002.006	Atkasuk
1851-5	R1.02.002.002.007	Barrow
1852-3	R1.02.002.002.008	Bering Straits Inupiat
1853-1	R1.02.002.002.009	Brevig Mission
1854-9	R1.02.002.002.010	Buckland
1855-6	R1.02.002.002.011	Chinik
1856-4	R1.02.002.002.012	Council
1857-2	R1.02.002.002.013	Deering
1858-0	R1.02.002.002.014	Elim
1859-8	R1.02.002.002.015	Golovin
1860-6	R1.02.002.002.016	Inalik Diomedes
1861-4	R1.02.002.002.017	Inupiaq
1862-2	R1.02.002.002.018	Kaktovik
1863-0	R1.02.002.002.019	Kawerak
1864-8	R1.02.002.002.020	Kiana
1865-5	R1.02.002.002.021	Kivalina
1866-3	R1.02.002.002.022	Kobuk
1867-1	R1.02.002.002.023	Kotzebue
1868-9	R1.02.002.002.024	Koyuk
1869-7	R1.02.002.002.025	Kwiguk
1870-5	R1.02.002.002.026	Mauneluk Inupiat
1871-3	R1.02.002.002.027	Nana Inupiat
1872-1	R1.02.002.002.028	Noatak
1873-9	R1.02.002.002.029	Nome
1874-7	R1.02.002.002.030	Noorvik

1875-4	R1.02.002.002.031	Nuiqsut
1876-2	R1.02.002.002.032	Point Hope
1877-0	R1.02.002.002.033	Point Lay
1878-8	R1.02.002.002.034	Selawik
1879-6	R1.02.002.002.035	Shaktoolik
1880-4	R1.02.002.002.036	Shishmaref
1881-2	R1.02.002.002.037	Shungnak
1882-0	R1.02.002.002.038	Solomon
1883-8	R1.02.002.002.039	Teller
1884-6	R1.02.002.002.040	Unalakleet
1885-3	R1.02.002.002.041	Wainwright
1886-1	R1.02.002.002.042	Wales
1887-9	R1.02.002.002.043	White Mountain
1888-7	R1.02.002.002.044	White Mountain Inupiat
1889-5	R1.02.002.002.045	Mary's Igloo
1891-1	R1.02.002.003	Siberian Eskimo
1892-9	R1.02.002.003.001	Gambell
1893-7	R1.02.002.003.002	Savoonga
1894-5	R1.02.002.003.003	Siberian Yupik
1896-0	R1.02.002.004	Yupik Eskimo
1897-8	R1.02.002.004.001	Akiachak
1898-6	R1.02.002.004.002	Akiak
1899-4	R1.02.002.004.003	Alakanuk
1900-0	R1.02.002.004.004	Aleknagik
1901-8	R1.02.002.004.005	Andreafsky
1902-6	R1.02.002.004.006	Aniak
1903-4	R1.02.002.004.007	Atmautluak
1904-2	R1.02.002.004.008	Bethel
1905-9	R1.02.002.004.009	Bill Moore's Slough
1906-7	R1.02.002.004.010	Bristol Bay Yupik
1907-5	R1.02.002.004.011	Calista Yupik
1908-3	R1.02.002.004.012	Chefornak
1909-1	R1.02.002.004.013	Chevak
1910-9	R1.02.002.004.014	Chuathbaluk
1911-7	R1.02.002.004.015	Clark's Point
1912-5	R1.02.002.004.016	Crooked Creek
1913-3	R1.02.002.004.017	Dillingham
1914-1	R1.02.002.004.018	Eek
1915-8	R1.02.002.004.019	Ekuk
1916-6	R1.02.002.004.020	Ekwok
1917-4	R1.02.002.004.021	Emmonak
1918-2	R1.02.002.004.022	Goodnews Bay
1919-0	R1.02.002.004.023	Hooper Bay
1920-8	R1.02.002.004.024	Iqurmuit (Russian Mission)
1921-6	R1.02.002.004.025	Kalskag
1922-4	R1.02.002.004.026	Kasigluk
1923-2	R1.02.002.004.027	Kipnuk
1924-0	R1.02.002.004.028	Koliganek
1925-7	R1.02.002.004.029	Kongiganak
1926-5	R1.02.002.004.030	Kotlik
1927-3	R1.02.002.004.031	Kwethluk
1928-1	R1.02.002.004.032	Kwigillingok
1929-9	R1.02.002.004.033	Levelock
1930-7	R1.02.002.004.034	Lower Kalskag
1931-5	R1.02.002.004.035	Manokotak
1932-3	R1.02.002.004.036	Marshall
1933-1	R1.02.002.004.037	Mekoryuk
1934-9	R1.02.002.004.038	Mountain Village
1935-6	R1.02.002.004.039	Naknek
1936-4	R1.02.002.004.040	Napaumute
1937-2	R1.02.002.004.041	Napakiak
1938-0	R1.02.002.004.042	Napaskiak
1939-8	R1.02.002.004.043	Newhalen

1940-6	R1.02.002.004.044	New Stuyahok
1941-4	R1.02.002.004.045	Newtok
1942-2	R1.02.002.004.046	Nightmute
1943-0	R1.02.002.004.047	Nunapitchukv
1944-8	R1.02.002.004.048	Oscarville
1945-5	R1.02.002.004.049	Pilot Station
1946-3	R1.02.002.004.050	Pitkas Point
1947-1	R1.02.002.004.051	Platinum
1948-9	R1.02.002.004.052	Portage Creek
1949-7	R1.02.002.004.053	Quinhagak
1950-5	R1.02.002.004.054	Red Devil
1951-3	R1.02.002.004.055	St. Michael
1952-1	R1.02.002.004.056	Scammon Bay
1953-9	R1.02.002.004.057	Sheldon's Point
1954-7	R1.02.002.004.058	Sleetmute
1955-4	R1.02.002.004.059	Stebbins
1956-2	R1.02.002.004.060	Togiak
1957-0	R1.02.002.004.061	Toksook
1958-8	R1.02.002.004.062	Tulukskak
1959-6	R1.02.002.004.063	Tuntutuliak
1960-4	R1.02.002.004.064	Tununak
1961-2	R1.02.002.004.065	Twin Hills
1962-0	R1.02.002.004.066	Georgetown
1963-8	R1.02.002.004.067	St. Mary's
1964-6	R1.02.002.004.068	Umkumiate
1966-1	R1.02.003	Aleut
1968-7	R1.02.003.001	Alutiiq Aleut
1969-5	R1.02.003.001.001	Tatitlek
1970-3	R1.02.003.001.002	Ugashik
1972-9	R1.02.003.002	Bristol Bay Aleut
1973-7	R1.02.003.002.001	Chignik
1974-5	R1.02.003.002.002	Chignik Lake
1975-2	R1.02.003.002.003	Egegik
1976-0	R1.02.003.002.004	Igiugig
1977-8	R1.02.003.002.005	Ivanof Bay
1978-6	R1.02.003.002.006	King Salmon
1979-4	R1.02.003.002.007	Kokhanok
1980-2	R1.02.003.002.008	Perryville
1981-0	R1.02.003.002.009	Pilot Point
1982-8	R1.02.003.002.010	Port Heiden
1984-4	R1.02.003.003	Chugach Aleut
1985-1	R1.02.003.003.001	Chenega
1986-9	R1.02.003.003.002	Chugach Corporation
1987-7	R1.02.003.003.003	English Bay
1988-5	R1.02.003.003.004	Port Graham
1990-1	R1.02.003.004	Eyak
1992-7	R1.02.003.005	Koniag Aleut
1993-5	R1.02.003.005.001	Akhiok
1994-3	R1.02.003.005.002	Agdaagux
1995-0	R1.02.003.005.003	Karluk
1996-8	R1.02.003.005.004	Kodiak
1997-6	R1.02.003.005.005	Larsen Bay
1998-4	R1.02.003.005.006	Old Harbor
1999-2	R1.02.003.005.007	Ouzinkie
2000-8	R1.02.003.005.008	Port Lions
2002-4	R1.02.003.006	Sugpiaq
2004-0	R1.02.003.007	Suqpiqaq
2006-5	R1.02.003.008	Unangan Aleut
2007-3	R1.02.003.008.001	Akutan
2008-1	R1.02.003.008.002	Aleut Corporation
2009-9	R1.02.003.008.003	Aleutian
2010-7	R1.02.003.008.004	Aleutian Islander
2011-5	R1.02.003.008.005	Atka

2012-3	R1.02.003.008.006	Belkofski
2013-1	R1.02.003.008.007	Chignik Lagoon
2014-9	R1.02.003.008.008	King Cove
2015-6	R1.02.003.008.009	False Pass
2016-4	R1.02.003.008.010	Nelson Lagoon
2017-2	R1.02.003.008.011	Nikolski
2018-0	R1.02.003.008.012	Pauloff Harbor
2019-8	R1.02.003.008.013	Qagan Toyagungin
2020-6	R1.02.003.008.014	Qawalangin
2021-4	R1.02.003.008.015	St. George
2022-2	R1.02.003.008.016	St. Paul
2023-0	R1.02.003.008.017	Sand Point
2024-8	R1.02.003.008.018	South Naknek
2025-5	R1.02.003.008.019	Unalaska
2026-3	R1.02.003.008.020	Unga

Race Concepts for Asian

Unique Identifier	Hierarchical Code	Concept
2028-9	R2	Asian
2029-7	R2.01	Asian Indian
2030-5	R2.02	Bangladeshi
2031-3	R2.03	Bhutanese
2032-1	R2.04	Burmese
2033-9	R2.05	Cambodian
2034-7	R2.06	Chinese
2035-4	R2.07	Taiwanese
2036-2	R2.08	Filipino
2037-0	R2.09	Hmong
2038-8	R2.10	Indonesian
2039-6	R2.11	Japanese
2040-4	R2.12	Korean
2041-2	R2.13	Laotian
2042-0	R2.14	Malaysian
2043-8	R2.15	Okinawan
2044-6	R2.16	Pakistani
2045-3	R2.17	Sri Lankan
2046-1	R2.18	Thai
2047-9	R2.19	Vietnamese
2048-7	R2.20	Iwo Jiman
2049-5	R2.21	Maldivian
2050-3	R2.22	Nepalese
2051-1	R2.23	Singaporean
2052-9	R2.24	Madagascar

Race Concepts for Black or African American

Unique Identifier	Hierarchical Code	Concept
2054-5	R3	Black or African American
2056-0	R3.01	Black
2058-6	R3.02	African American
2060-2	R3.03	African
2061-0	R3.03.001	Botswanan
2062-8	R3.03.002	Ethiopian
2063-6	R3.03.003	Liberian
2064-4	R3.03.004	Namibian
2065-1	R3.03.005	Nigerian
2066-9	R3.03.006	Zairean
2067-7	R3.04	Bahamian
2068-5	R3.05	Barbadian
2069-3	R3.06	Dominican
2070-1	R3.07	Dominica Islander
2071-9	R3.08	Haitian
2072-7	R3.09	Jamaican
2073-5	R3.10	Tobagoan
2074-3	R3.11	Trinidadian
2075-0	R3.12	West Indian

Race Concepts for Native Hawaiian or Other Pacific Islander

Unique Identifier	Hierarchical Code	Concept
2076-8	R4	Native Hawaiian or Other Pacific Islander
2078-4	R4.01	Polynesian
2079-2	R4.01.001	Native Hawaiian
2080-0	R4.01.002	Samoaan
2081-8	R4.01.003	Tahitian
2082-6	R4.01.004	Tongan
2083-4	R4.01.005	Tokelauan
2085-9	R4.02	Micronesian
2086-7	R4.02.001	Guamanian or Chamorro
2087-5	R4.02.002	Guamanian
2088-3	R4.02.003	Chamorro
2089-1	R4.02.004	Mariana Islander
2090-9	R4.02.005	Marshallese
2091-7	R4.02.006	Palauan
2092-5	R4.02.007	Carolinian
2093-3	R4.02.008	Kosraean
2094-1	R4.02.009	Pohnpeian
2095-8	R4.02.010	Saipanese
2096-6	R4.02.011	Kiribati
2097-4	R4.02.012	Chuukese
2098-2	R4.02.013	Yapese
2100-6	R4.03	Melanesian
2101-4	R4.03.001	Fijian
2102-2	R4.03.002	Papua New Guinean
2103-0	R4.03.003	Solomon Islander
2104-8	R4.03.004	New Hebrides
2500-7	R4.04	Other Pacific Islander

Race Concepts for White

Unique Identifier	Hierarchical Code	Concept
2106-3	R5	White
2108-9	R5.01	European
2109-7	R5.01.001	Armenian
2110-5	R5.01.002	English
2111-3	R5.01.003	French
2112-1	R5.01.004	German
2113-9	R5.01.005	Irish
2114-7	R5.01.006	Italian
2115-4	R5.01.007	Polish
2116-2	R5.01.008	Scottish
2118-8	R5.02	Middle Eastern or North African
2119-6	R5.02.001	Assyrian
2120-4	R5.02.002	Egyptian
2121-2	R5.02.003	Iranian
2122-0	R5.02.004	Iraqi
2123-8	R5.02.005	Lebanese
2124-6	R5.02.006	Palestinian
2125-3	R5.02.007	Syrian
2126-1	R5.02.008	Afghanistani
2127-9	R5.02.009	Israeili
2129-5	R5.03	Arab

Race Concepts for Other

Unique Identifier	Hierarchical Code	Concept
2131-1	R9	Other Race

Appendix D: Ethnicity Concepts

Ethnicity Concepts for Hispanic or Latino

Unique Identifier	Hierarchical Code	Concept
2135-2	E1	Hispanic or Latino
2137-8	E1.01	Spaniard
2138-6	E1.01.001	Andalusian
2139-4	E1.01.002	Asturian
2140-2	E1.01.003	Castillian
2141-0	E1.01.004	Catalonian
2142-8	E1.01.005	Belearic Islander
2143-6	E1.01.006	Gallego
2144-4	E1.01.007	Valencian
2145-1	E1.01.008	Canarian
2146-9	E1.01.009	Spanish Basque
2148-5	E1.02	Mexican
2149-3	E1.02.001	Mexican American
2150-1	E1.02.002	Mexicano
2151-9	E1.02.003	Chicano
2152-7	E1.02.004	La Raza
2153-5	E1.02.005	Mexican American Indian
2155-0	E1.03	Central American
2156-8	E1.03.001	Costa Rican
2157-6	E1.03.002	Guatemalan
2158-4	E1.03.003	Honduran
2159-2	E1.03.004	Nicaraguan
2160-0	E1.03.005	Panamanian

Appendix E: Document Source

Inpatient Record

First level source	Secondary level source	Description
A01 = Inpatient Record	A01.01	IP/Acute Care Facility
	A01.01.01	IP/ACF/Infection Control Practitioner
	A01.01.02	IP/ACF/OBGYN records
	A01.01.02.01	IP/ACF/OBGYN/Prenatal Care records
	A01.01.02.02	IP/ACF/OBGYN/Labor & Delivery records
	A01.01.03	IP/ACF/Pediatric records
	A01.01.04	IP/ACF/Birth records
	A01.01.05	IP/ACF/All other records
	A01.02	IP/Veterans Administration Hospital
	A01.02.01	IP/VA/Infection Control Practitioner
	A01.02.02	IP/VA/All other records
	A01.03	IP/Military Hospital
	A01.03.01	IP/MH/Infection Control Practitioner
	A01.03.02	IP/MH/OBGYN records
	A01.03.02.01	IP/MH/OBGYN/Prenatal Care records
	A01.03.02.02	IP/MH/OBGYN/Labor & Delivery records
	A01.03.03	IP/MH/Pediatric records
	A01.03.04	IP/MH/All other records
	A01.04	IP/Long Term Care Facility
	A01.04.01	IP/LTCF/Nursing Home
	A01.04.02	IP/LTCF/Rehabilitation Center
	A01.04.03	IP/LTCF/Drug Treatment Program
	A01.05	IP/Hospice

Outpatient Record

First level source	Secondary level source	Description
A02 = Outpatient Record	A02.01	OP/HMO
	A02.01.01	OP/HMO/Hospital Associated Outpatient clinic
	A02.01.02	OP/HMO/Non-Hospital Associated Outpatient clinic
	A02.02	OP/ VA Outpatient clinic
	A02.03	OP/Private Physician
	A02.03.01	OP/PP/Hospital Associated Outpatient clinic
	A02.03.02	OP/PP/Non-Hospital Associated Outpatient clinic
	A02.04	OP/Adult HIV Clinic
	A02.04.01	OP/Adult HIV Clinic/Hospital Associated Outpatient clinic
	A02.04.02	OP/Adult HIV Clinic/Non-Hospital Associated Outpatient clinic
	A02.05	OP/Infectious Disease clinic
	A02.05.01	OP/IDC/Hospital Associated Outpatient clinic
	A02.05.02	OP/IDC/Non-Hospital Associated Outpatient clinic
	A02.06	OP/County Health Department clinic
	A02.07	OP/Maternal HIV Clinic
	A02.07.01	OP/Maternal HIV Clinic/Hospital Associated Outpatient clinic
	A02.07.02	OP/Maternal HIV Clinic/Non-Hospital Associated Outpatient clinic

	A02.08	OP/Prenatal Clinic or Records
	A02.08.01	OP/PRC/Hospital Associated Outpatient clinic
	A02.08.02	OP/PRC/Non-Hospital Associated Outpatient clinic
	A02.09	OP/Pediatric HIV Clinic
	A02.09.01	OP/Pediatric HIV Clinic/Hospital Associated Outpatient clinic
	A02.09.02	OP/Pediatric HIV Clinic/Non-Hospital Associated Outpatient clinic
	A02.10	OP/Obstetrics and Gynecology
	A02.10.01	OP/OBGYN/Hospital Associated Outpatient clinic
	A02.10.02	OP/OBGYN/Non-Hospital Associated Outpatient clinic
	A02.11	OP/Pediatric clinic
	A02.11.01	OP/PC/Hospital Associated Outpatient clinic
	A02.11.02	OP/PC/Non-Hospital Associated Outpatient clinic
	A02.12	OP/TB clinic
	A02.12.01	OP/TB Clinic/Hospital Associated Outpatient clinic
	A02.12.02	OP/TB Clinic/Non-Hospital Associated Outpatient clinic
	A02.13	OP/HRSA funded clinic
	A02.14	OP/Indian Health Service clinic
	A02.14.01	OP/IHS/Hospital Associated Outpatient clinic
	A02.14.02	OP/IHS/Non-Hospital Associated Outpatient clinic
	A02.15	OP/Early Intervention Nurse
	A02.15.01	OP/EIN/Hospital Associated Outpatient clinic
	A02.15.02	OP/EIN/Non-Hospital Associated Outpatient clinic
	A02.16	OP/Visiting Nurse Service
	A02.16.01	OP/VNS/Hospital Associated
	A02.16.02	OP/VNS/Non-Hospital Associated
	A02.17	OP/Hemophilia Treatment Center
	A02.17.01	OP/HTC/Hospital Associated Outpatient clinic
	A02.17.02	OP/HTC/Non-Hospital Associated Outpatient clinic
	A02.18	OP/Hospice
	A02.18.01	OP/Hospice/Hospital Associated Outpatient clinic
	A02.18.02	OP/Hospice/Non-Hospital Associated Outpatient clinic
	A02.19	OP/Drug Treatment Center
	A02.19.01	OP/DTC/Hospital Associated Outpatient clinic
	A02.19.02	OP/DTC/Non-Hospital Associated Outpatient clinic
	A02.20	OP/Rehabilitation Center
	A02.20.01	OP/RC/Hospital Associated Outpatient clinic
	A02.20.02	OP/RC/Non-Hospital Associated Outpatient clinic
	A02.25	OP/Other Clinic
	A02.25.01	OP/Other/Hospital Associated Outpatient clinic
	A02.25.02	OP/Other/Non-Hospital Associated Outpatient clinic

Emergency Room

First level source	Secondary level source	Description
A03 = Emergency Room	A03	Emergency room record not resulting in admission

Screening, Diagnosis and Referral Agencies

First level source	Secondary level source	Description
A04 = Screening, Diagnosis and Referral Agencies	A04.01	SDRA/Blood Bank
	A04.02	SDRA/Drug Treatment Clinic or Program
	A04.03	SDRA/Family Planning Clinic
	A04.04	SDRA/HIV Case Management Agency
	A04.05	SDRA/HIV Counseling and Testing Site
	A04.06	SDRA/Immigration
	A04.07	SDRA/Insurance report
	A04.08	SDRA/Job Corps
	A04.09	SDRA/Military
	A04.10	SDRA/Partner Counseling and Referral Services
	A04.11	SDRA/STD Clinic
	A04.12	SDRA/Public Health Notes

Laboratories

First level source	Secondary level source	Description
A05 = Laboratories	A05.01	Laboratory/Hospital laboratory
	A05.02	Laboratory/State laboratory
	A05.03	Laboratory/Private laboratory
	A05.03.01	Laboratory/Private/Reference laboratory
	A05.03.02	Laboratory/Private/Other laboratory

Other Databases of Information

First level source	Secondary level source	Description
A06 = Other databases of information	A06.01	Other DB/AIDS Drug Assistance Program (ADAP)
	A06.02	Other DB/ASD database
	A06.03	Other DB/Birth Certificate
	A06.04	Other DB/Birth Defects registry
	A06.05	Other DB/Cancer registry
	A06.06	Other DB/Database provided by coroner not associated with inpatient facility
	A06.07	Other DB/Death Certificate
	A06.08	Other DB/EHRAP database
	A06.09	Other DB/EPS database
	A06.10	Other DB/HARS database
	A06.11	Other DB/Health department records
	A06.12	Other DB/Hepatitis registry
	A06.13	Other DB/Hospital billing summary or Discharge db
	A06.14	Other DB/HRSA HIV CARE database
	A06.15	Other DB/Immunization registry
	A06.16	Other DB/Medicaid records
	A06.17	Other DB/National Death Index (NDI) Search
	A06.18	Other DB/Out of State Report

	A06.19	Other DB/Prison, Jail or other Correctional Facility database
	A06.20	Other DB/PSD database
	A06.21	Other DB/State Disease registry
	A06.22	Other DB/SHAS database
	A06.23	Other DB/SHDC database
	A06.24	Other DB/STD registry
	A06.25	Other DB/Tuberculosis registry
	A06.27	Other DB/Vital Statistics (state/local)
	A06.28	Other DB/HARS NDI
	A06.29	Other DB/RIDR
	A06.30	Other DB/Social Security Death Master File (SSDMF) or Social Security Death Index (SSDI)
	A06.50	Other DB/Other database or report

Other Facility Records

First level source	Secondary level source	Description
A07 = Other Facility Records	A07.01	OFR/Prison, jail or other correctional facility
	A07.02	OFR/Coroner not associated with inpatient facility

Other Source

First level source	Secondary level source	Description
A10 = Other Source	A10.01	Other Source/COPHI Investigation
	A10.02	Other Source/Patient Interview