PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT FORM

District of Columbia Department of Health
HIV/AIDS Administration
Bureau of Surveillance and Epidemiology
Telephone: (202) 671-4900

The Pediatric HIV/AIDS Confidential Case Report form is to be used to report both HIV infection and AIDS in individuals less than 13 years of age at the time of diagnosis. Please note that HIV infection reporting has been updated to include the patient's name and other relevant patient information. HIV infection and AIDS cases are reportable to the District of Epidemiology, and only that program (Federal law-Section 308 (d) of the Public Health Service Act (422 USC 242m). All cases are to be reported by name. Mail completed reports in a double-sealed envelope marked "CONFIDENTIAL" to:

Department of Health
BOX 19
644 New York Avenue, NE
Washington, D.C. 20002

For additional information about reporting procedures and recent changes, please contact the Bureau of Surveillance and Epidemiology. For assistance, please call 202-671-4900 or visit the HIV/AIDS website at www.doh.dc.gov.

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

HIV/AIDS ADMINISTRATION

Pediatric HIV/AIDS Confidential Case Report

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

I. PATIENT IDENTIFIER INFORMATION *(SHADED AREAS FOR HEALTH DEPARTMENT USE ONLY)* Please Write Legibility

Last Name:	**State Patient No.**	**Report Status:** ❑ New Report ❑ Update	**Laboratory Tracking Number:**
First Name:			
Middle Initial:	**Soundex Code:**	**Report Source:**	**Date Form Entered:** ____/____/____

Date Form Completed:

Month	Day	Year

Address: _____ Apt#:_____ Telephone No.: (____)_____

City: _____ County: _____ Ward: _____ State: _____ Zip Code: _____

Diagnostic Status at Report: (select one)

- ❑ Prenatally HIV Exposed (not AIDS)
- ❑ Confirmed HIV (not AIDS)
- ❑ Seroreverter
- ❑ AIDS

Date of Last Medical Evaluation

Month Day Year

Date of Last Medical Evaluation

	Months	Years
HIV Infection (not AIDS). . .		
AIDS.		

Sex:

1	Male
2	Female
3	Intersex
9	Unknown

Date of Birth:

MM Day YYYY

Social Security No.:

Date of Birth:

- 1 **U.S.**
- 7 **U.S. Dependencies and Possessions (including Puerto Rico) (specify)** _____
- 8 **Other (specify)**_____
- 9 **Unknown**

Current Status:

- ❑ Alive
- ❑ Dead
- ❑ Unknown

Date of Death:

Month Day Year

Date of initial evaluation for HIV infection (mm/yr):

Month Year

State/Country/Territory of Death:

State _____

Country _____

Territory _____

Was reason for initial HIV evaluation due to clinical signs and symptoms?

- ❑ Yes
- ❑ No
- ❑ Unknown

Ethnicity: (select one) ❑ Hispanic ❑ Not Hispanic or Latino ❑ Unknown

If Hispanic, please check one: ❑ Mexican ❑ Puerto Rican ❑ Cuban ❑ Central American ❑ South American ❑ Other (specify) _____

Race: (select one or more)

❑ American Indian/Alaska/Native ❑ Native Hawaiian or Other Pacific Islander ❑ Asian ❑ Black or African ❑ White ❑ Unknown

Residence at Diagnosis ***(Specify Country of Birth if not U.S.)***

City: _____ **County** _____ **State/Country** _____ **Zip Code:** _____

II. FACILITY OF DIAGNOSIS Please Write Legibly

Facility Name:	**City:**	**State/Country:**
Facility Setting: (check one) ❑ Public ❑ Private ❑ Federal ❑ Unknown	**Facility Type:** (check one) ❑ Physician, HMO ❑ Hospital, Inpatient ❑ Hospital, Outpatient ❑ Community Health Center Other (specify) _____	**Facility Phone Number:** Other ( ) _____

II. MATERNAL DEMOGRAPHICS AND HISTORY (Respond to All categories) Please Write Legible

Child's biologic mother's HIV/AIDS: (check one) ❑ Refused HIV testing ❑ Known to be uninfected after this child's birth ❑ HIV status unknown

Diagnosed with HIV infection/AIDS: (check one) ❑ Before this child's pregnancy ❑ At time of delivery ❑ Before child's birth, exact period unknown ❑ After the child's birth ❑ HIV-infected, unknown when diagnosed

Date of mother's first positive HIV confirmatory test: MM YY

Mother was counseled about HIV testing during this pregnancy, labor or delivery?.....	Yes	No	Unk.
	❑	❑	❑

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This child's biologic mother had:	Yes	No	Unk.
Injected non prescription drugs	❑	❑	❑
HETEROSEXUAL relations with any of the following:			
Intravenous/injection drug user	❑	❑	❑
Bisexual male	❑	❑	❑
Male with hemophilia/coagulation disorder	❑	❑	❑
Transfusion recipient with documented HIV infection	❑	❑	❑
Transplant recipient with documented HIV infection	❑	❑	❑
Male with AIDS or documented HIV infection, risk not specified	❑	❑	❑
Received transfusion of blood/blood components (other than clotting factor)	❑	❑	❑
Received transplant to tissue/organs or artificial insemination	❑	❑	❑

Before the diagnosis of HIV infection/AIDS, this child had:	Yes	No	Unk.
Received clotting factor for hemophilia/coagulation disorder	❑	❑	❑
Specify disorder: ❑ Factor VII (Hemophilia A) ❑ Factor IX (Hemophilia B) ❑ Other (Specify): _____			
Received transfusion of blood/blood components (other than clotting factor) First: Month Year: Last Month Year:	❑	❑	❑
Received transplant of Tissue/organs	❑	❑	❑
Sexual contact with a male	❑	❑	❑
Sexual contact with a female	❑	❑	❑
Injected nonprescription drugs	❑	❑	❑
Other (Alert Bureau of Surveillance and Epidemiology)	❑	❑	❑
Specify	❑	❑	❑

IV. BIRTH HISTORY (For Perinatal Cases Only) Please Write Legibly

Birth history was available for this child? ❑ Yes ❑ No ❑ Unknown **(If No or Unknown, proceed to Section V.)**

Hospital at Birth:

Hospital _____ City _____ State/Country _____

Residence at Birth:

Hospital _____ City _____ Zip Code _____

Birth weight:
(enter lbs/oz. OR grams)
lbs. oz.
grams

Birth Type
❑ Single
❑ Twin
❑ > 2
❑ Unknown

Neonatal Status:
❑ Full term ❑ Premature
Weeks at birth: ❑ Unknown

Birth Defects:
❑ Yes
❑ No
❑ Unknown

Specify Birth Defect:

Code: -

Delivery: (Select one)
❑ Vaginal
❑ Elective Caesarean
❑ Non-elective Caesarean
❑ Caesarean unknown type
❑ Unknown

Prenatal Care
❑ Yes ❑ No ❑ Unknown
If yes, month prenatal care began:
Mos. Unknown
Total number of prenatal visits:
No. Unknown

Did mother receive zidovudine (ZDV, AZT) during pregnancy?
❑ Refused ❑ Yes ❑ No ❑ Unknown

Did mother receive zidovudine (ZDV, AZT) during labor/delivery?
❑ Refused ❑ Yes ❑ No ❑ Unknown

Did mother receive any other anti-retroviral medication during pregnancy? ❑ Yes ❑ No ❑ Unknown
If yes, please specify: _____

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

Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?
❑ Yes ❑ No ❑ Unknown

Did mother receive any other anti-retroviral medication during labor/delivery? ❑ Yes ❑ No ❑ Unknown
If yes, please specify: _____

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V. LABORATORY DATA — Please Write Legibly

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	Test Date	
HIV-1 EIA	❑	❑	❑	❑	MM:	YYYY:
HIV-1 EIA	❑	❑	❑	❑	MM:	YYYY:
HIV-1/HIV-combination EIA	❑	❑	❑	❑	MM:	YYYY:
HIV-1/HIV-2 combination EIA	❑	❑	❑	❑	MM:	YYYY:
HIV-1 Western blot/IFA	❑	❑	❑	❑	MM:	YYYY:
HIV-1 Western blot/IFA	❑	❑	❑	❑	MM:	YYYY:
Other HIV antibody test (specify):_____	❑	❑	❑	❑	MM:	YYYY:

2. HIV DETECTION TEST: (Record all tests, include earliest positive)

	Test Results: Positive	Negative	Not Done	Test Date:			Test Results: Positive	Negative	Not Done	Test Date:	
HIV culture	❑	❑	❑	MM:	YYYY:	HIV DNA PCR	❑	❑	❑	MM:	YYYY:
HIV culture	❑	❑	❑	MM:	YYYY:	HIV DNA PCR	❑	❑	❑	MM:	YYYY:
HIV antigen test	❑	❑	❑	MM:	YYYY:	HIV RNA PCR	❑	❑	❑	MM:	YYYY:
HIV antigen test	❑	❑	❑	MM:	YYYY:	HIV RNA PCR	❑	❑	❑	MM:	YYYY:
						Other, specify _____					

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable) *Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

Test Type*	Detectable	Copies/ml	Test Date MM	Test Date YYYY	Test Type*	Detectable	Copies/ml	Test Date MM	Test Date YYYY
	❑ Yes ❑ No					❑ Yes ❑ No			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnosis status)

CD4 Count	MM	YYYY
____,_____cells/ul		
____,_____cells/ul		
CD4 Percent		
%		
%		

5. If HIV tests were not positive or were not done, ore the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition?

❑ Yes ❑ No ❑ Unknown

6. If HIV laboratory tests were not documented, is patient confirmed by a physical as

				Date of Documentation MM:	YYYY:
HIV-infected	❑ Yes	❑ No	❑ Unknown	____	____
Not HIV-infected	❑ Yes	❑ No	❑ Unknown	____	____

VI. MATERNAL INFORMATION — Please Write Legibly

Mother's Name:

_____

(Last, First, M.I.)

AKA or Maiden Name_____

Maternal Date of Birth: Month	Day	Day	Year	Maternal Soundex:	Maternal State Patient No. (Health Department Use Only)
				Maternal UI code:	

Birthplace of Biologic Mother:

❑ U.S. ❑ U.S. Dependencies and Possessions (including Puerto Rico) (specify) _____

❑ Other (specify) _____ ❑ Unknown

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VII. CLINICAL STATUS — Please Write Legibly

AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date		AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date	
	Def.	Pres.	Mo. (mm)	Yr. (yy)		Def.	Pres.	Mo. (mm)	Yr. (yy)
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1				Kaposi's Sarcoma	1			
Candidiasis, bronchi, trachea, or lungs	1				Lymphoid intestitial pneumonia and/or pulmonary lymphoid hyperplasia	1			
Candidiasis, esophageal	1				Lymphoma, Burkit's (or equivalent term)	1			
Coccidioidomycosis, disseminated or extrapulmonary	1				Lymphoma, immunoblastic (or equivalent term)	1			
Cryptococcosis, Extrapulmonary	1				Lymphoma, primary in brain	1			
Cryptosporidiosis, chronic intestinal (<1 month duration)	1				Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	1			
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 month of age	1				M.tuberculosis, disseminated or extrapulmonary*	1			
Cytomegalovirus retinitis (with loss of vision)	1				Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1			
HIV encephalopathy	1				Pneumocystis carinii pneumonia	1			
Herpes simplex: chronic ulcer(s) >1 month duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age	1				Pneumocystis carinii pneumonia	1			
Histoplasmosis, disseminated or extrapulmonary	1				Progressive multifocal leukoencephalopathy	1			
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1				Toxoplasmosis of brain, onset at >1 month of age	1			
Isosporiasis, chronic intestinal >1 month duration	1				Wasting syndrome due to HIV	1			

Def. = definitive diagnosis Pres.=presumptive diagnosis

* Has this child been diagnosed with pulmonary tuberculosis?	Yes	No	Unk.		If yes, initial diagnosis date	Def.	Pres.	Mo.	Yr.
						1	2		

RVCT Case Number _____

VIII. TREATMENTS/SERVICES AND REFERRALS — Please Write Legibly

This child received or is receiving:

		DATE STARTED (MM DD YYYY)		DATE STARTED (MM DD YYYY)
Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	❑ Yes ❑ No ❑ Unk.		Anti-retroviral therapy for HIV *treatment* ❑ Yes ❑ No ❑ Unk.	
Other neonatal anti-retroviral medication for HIV *prevention*	❑ Yes ❑ No ❑ Unk.			
If yes, specify: _____			PCP prophylaxis ❑ Yes ❑ No ❑ Unk.	

Was child breastfed?

❑ Yes

❑ No

❑ Unknown

This child has been enrolled at:

Clinic Trial:

❑ NIH-sponsored

❑ Other

❑ None

❑ Unknown

Clinic Trial:

❑ HRSA-Sponsored

❑ None

❑ Other

❑ Unknown

This child's medical treatment is primarily reimbursed by:

❑ Medicaid

❑ Private Insurance/HMO

❑ Alliance

❑ No Coverage

❑ Other Public Funding

❑ Clinical Trial

❑ Ryan White Funding

❑ Unknown

The child's primary caretaker is:

❑ Biological Parent(s)

❑ Foster/Adoptive parent, unrelated

❑ Other (specify in section XI)

❑ Other relative

❑ Social service agent

❑ Foster/Adoptive parent, related

❑ Unknown

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IX. PROVIDER INFORMATION — Please Write Legibly

Provider's Name:	Phone Number:	Address:
Medical Record Number:	(_____) _____	
Hospital/Facility:	Person Completing Form:	Fax: (_____)_____
Email:		

X. HEALTH DEPARTMENT USE ONLY

Casework needed to complete report:

00 = arrived complete
01 = demographic data
02 = residence at diagnosis
03 = hospital/facility
04 = risk factor
05 = date of first dx
06 = laboratory data
07 = physician info
08 = patient identifier
11 = clinical status/AIDS or OIs
12 = treatment/services referral
13 = HIV testing hx
14 = maternal demographics and hx
15 = birth history

NIR Status: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.

NIR ☐ Yes ☐ No

☐ Physician notified by telephone
☐ Physician notified by letter
☐ Returned for additional investigation
☐ Date _____

Current Status: date / /

1 = open (still being investigated)
2 = closed-dead
3 = closed-refused
4 = closed-lost to follow-up
5 = investigated (risk still unknown)
6 = reclassified (risk has been found)
Enter month/year resolved _____

Current Status: date / /

1 = open (still being investigated)
2 = closed-dead
3 = closed-refused
4 = closed-lost to follow-up
5 = investigated (risk still unknown)
6 = reclassified (risk has been found)
Enter month/year resolved _____

Field Supervisor _____
Date reviewed / /
Follow-up date / /
Follow up plan _____

Components of Unique Identifier

First two letters of last name	Number of letters in last name	Gender	Date of Birth		
		1-Male	MM	DD	YYYY
		2-Female			

XI. COMMENTS — Please Write Legibly