PEDIATRIC HIV CONFIDENTIAL CASE REPORT FORM
(Patients aged <13 years at time of diagnosis)

Mail completed form to: Georgia Department of Public Health, Epidemiology Section P.O. Box 2107 Atlanta, GA 30301
For additional information: Phone: 1-800-827-9769 or visit our website at http://health.state.ga.us/epi/hivaids

All health care providers diagnosing and/or providing care to a patient with HIV are obligated to report using Georgia HIV/AIDS Case Report. Case reports should be completed within seven (7) days after diagnosing or providing care to a patient with HIV/AIDS. Providers are required to submit reports on any patient new to his or her care, regardless if they have previously received care elsewhere.

Patients ≥13 should be reported on an Adult Case Report Form (https://dph.georgia.gov/hivaids-case-reporting)

Patient Identification (record all dates as mm/dd/yyyy) *Information NOT transmitted to CDC

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (example: Birth, Call Me)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( )	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type	*Number	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( )
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	*Inpatient*: ☐ Hospital ☐ Other, specify_____	*Outpatient*: ☐ Private physician's office ☐ Pediatric clinic ☐ Pediatric HIV clinic ☐ Other, specify_____	*Other Facility*: ☐ Emergency room ☐ Laboratory ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form		*Phone ( )

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

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

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

Address Type (check all that apply to address below)	☐ Residence at HIV diagnosis	☐ Residence at stage 3 (AIDS) diagnosis	☐ Residence at perinatal exposure	☐ Residence at pediatric seroreverter	☐ Check if SAME as current address
*Street Address					
City	County	State/Country	*ZIP Code		

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Perinatal exposure ☐ Check if SAME as facility providing information			
Facility Name			***Phone** ( )
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**
Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Private physician's office ☐ Pediatric clinic ☐ Pediatric HIV clinic ☐ Other, specify _____		*Other Facility*: ☐ Emergency room ☐ Laboratory ☐ Unknown ☐ Other, specify _____
***Provider Name**	***Provider Phone** ( )	**Specialty**	

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Child's biological mother's HIV infection status (select one): ☐ 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

Date of mother's first positive test to confirm infection __ __ /__ __ /__ __ __ __

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, this child's biological mother had:	
Perinatally acquired HIV infection	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Biological mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Biological mother had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received__ __ /__ __ /__ __ __ __ Last date received__ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Before the diagnosis of HIV infection, this child had:	
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received__ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received__ __ /__ __ /__ __ __ __ Last date received__ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Clinical: Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

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

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

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay**
(differentiates between HIV-1 Ab and HIV-2 Ab)
Role of test in diagnostic algorithm
☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate
[1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
[2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) **Note: Include earliest test at or after diagnosis.**

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Collection Date __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

First CD4 result <200 cells/µL or <14%: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If laboratory tests were not documented, is patient confirmed by a physician as
HIV-infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis** __ __ /__ __ /__ __ __ __
Not HIV-infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis** __ __ /__ __ /__ __ __ __

Birth History (for Perinatal Cases only)

Residence at Birth	**Birth History Available** ☐ Yes ☐ No ☐ Unknown	☐ Check if SAME as current address
***Street Address**		**City**
County	**State/Country**	***ZIP Code**
Facility of Birth	☐ Check if SAME as facility providing information	
Facility Name of Birth (if child was born at home, enter "home birth")		***Phone** ( )
Facility Type	*Inpatient:* ☐ Hospital ☐ Other, specify_____	*Outpatient:* ☐ Other, specify_____ / *Other Facility*: ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify_____
***Street Address**		**City**
County	**State/Country**	***ZIP Code**
Birth History	**Birth Weight** _____lbs _____oz _____grams	**Type** ☐ 1-Single ☐ 2-Twin ☐ 3-More than two ☐ 9-Unknown
Delivery ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Nonelective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown		
Birth Defects ☐ Yes ☐ No ☐ Unknown	**If yes, specify types**	
Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ 9-Unknown	**Neonatal Gestational Age in Weeks** (99 = Unknown, 00 = None)	
Prenatal Care—Month of Pregnancy Prenatal Care Began (99 = Unknown, 00 = None)	**Prenatal Care—Total Number of Prenatal Care Visits** (99 = Unknown, 00 = None)	
Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown **Date began** __ __ / __ __ / __ __ __ __ **Date of last use** __ __ / __ __ / __ __ __ __	**If yes, specify all ARVs**	
Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown **Date began** __ __ / __ __ / __ __ __ __ **Date of last use** __ __ / __ __ / __ __ __ __	**If yes, specify all ARVs**	
Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Refused ☐ Unknown **Date began** __ __ / __ __ / __ __ __ __ **Date of last use** __ __ / __ __ / __ __ __ __	**If yes, specify all ARVs**	
Maternal Information	**Maternal DOB** __ __ / __ __ / __ __ __ __	**Maternal Last Name Soundex**
Maternal State ID Number	**Maternal Country of Birth**	
***Other Maternal ID (specify type of ID and ID number)**		

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

This child ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PrEP	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PEP	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PMTCT	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ HBV Tx	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ Other (specify reason)_____			
	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __

Has this child ever taken PCP prophylaxis ☐ Yes ☐ No ☐ Unknown Date began __ __ /__ __ /__ __ __ __ Date of last use __ __ /__ __ /__ __ __ __

Was this child breastfed? ☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is ☐ 1-Biological parent ☐ 2-Other relative ☐ 3-Foster/Adoptive parent, relative ☐ 4-Foster/Adoptive parent, unrelated ☐ 7-Social service agency ☐ 8-Other (please specify in comments) ☐ 9-Unknown

Comments