

**I. STATE/LOCAL USE ONLY**

Patient's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
(Last, First, M.I.)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**RETURN TO STATE/LOCAL HEALTH DEPARTMENT**

- Patient identifier information is not transmitted to CDC! -

Mail completed form to:  
Georgia Division of Public Health  
Epidemiology Branch  
P.O. Box #2107  
Atlanta, GA 30301

**PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT**  
(Patients <13 years of age at time of diagnosis)



**DATE FORM COMPLETED:**  
Mo. Day Yr.  
[ ][ ] [ ][ ] [ ][ ]

**II. HEALTH DEPARTMENT USE ONLY**

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

**SOUNDEX CODE:** [ ][ ][ ][ ] **REPORT STATUS:**  1 New Report  2 Update  
**REPORTING HEALTH DEPARTMENT:** State: \_\_\_\_\_ City/County: \_\_\_\_\_  
**State Patient No.:** [ ][ ][ ][ ][ ][ ][ ][ ][ ] **City/County Patient No.:** [ ][ ][ ][ ][ ][ ][ ][ ][ ]

**REPORT SOURCE:** [ ][ ][ ]

**III. DEMOGRAPHIC INFORMATION**

**DIAGNOSTIC STATUS AT REPORT:** (check one)  3 Perinatally HIV Exposed  4 Confirmed HIV Infection (not AIDS)  5 AIDS  6 Seroreverter  
**DATE OF LAST MEDICAL EVALUATION:** Mo. Yr. [ ][ ] [ ][ ]  
**DATE OF BIRTH:** Mo. Day Yr. [ ][ ] [ ][ ] [ ][ ] **AGE AT DIAGNOSIS:** HIV Infection (not AIDS) ... Years Months [ ][ ] [ ][ ] AIDS ..... [ ][ ] [ ][ ]  
**CURRENT STATUS:**  1 Alive  2 Dead  9 Unk. **DATE OF DEATH:** Mo. Day Yr. [ ][ ] [ ][ ] [ ][ ]  
**STATE/TERRITORY OF DEATH:** \_\_\_\_\_ **DATE OF INITIAL EVALUATION FOR HIV INFECTION:** Mo. Yr. [ ][ ] [ ][ ]  
**Was reason for initial HIV evaluation due to clinical signs and symptoms?** Yes No Unk.  1  0  9  
**SEX:**  1 Male  2 Female  
**ETHNICITY:** (select one)  1 Hispanic  2 Not Hispanic or Latino  9 Unk.  
**RACE:** (select one or more)  American Indian/Alaska Native  Native Hawaiian or Other Pacific Islander  Asian  White  Black or African American  Unk.  
**COUNTRY OF BIRTH:**  1 U.S.  7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): \_\_\_\_\_  8 Other (specify): \_\_\_\_\_  9 Unk.  
**RESIDENCE AT DIAGNOSIS:** City: \_\_\_\_\_ County: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code: [ ][ ][ ][ ] [ ][ ][ ][ ]

**IV. FACILITY OF DIAGNOSIS**

Facility Name: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_  
**FACILITY SETTING** (check one)  1 Public  2 Private  3 Federal  9 Unk. **FACILITY TYPE** (check one)  01 Physician, HMO  31 Hospital, Inpatient  88 Other (specify): \_\_\_\_\_

**V. PATIENT/MATERNAL HISTORY (Respond to ALL categories)**

**• Child's biologic mother's HIV Infection Status:** (check one)  1 Refused HIV testing  2 Known to be uninfected after this child's birth  9 HIV status unknown  
Diagnosed with HIV Infection/AIDS:  3 Before this child's pregnancy  5 At time of delivery  7 After the child's birth  
 4 During this child's pregnancy  6 Before child's birth, exact period unknown  8 HIV-infected, unknown when diagnosed  
**• Date of mother's first positive HIV confirmatory test:** Mo. Yr. [ ][ ] [ ][ ] **• Mother was counseled about HIV testing during this pregnancy, labor or delivery?** Yes No Unk.  1  0  9  
**After 1977, this child's biologic mother had:** Yes No Unk.  
• Injected nonprescription drugs .....  1  0  9  
• HETEROSEXUAL relations with:  
- Intravenous/injection drug user .....  1  0  9  
- Bisexual male .....  1  0  9  
- Male with hemophilia/coagulation disorder .....  1  0  9  
- Transfusion recipient with documented HIV infection .....  1  0  9  
- Transplant recipient with documented HIV infection .....  1  0  9  
- Male with AIDS or documented HIV infection, risk not specified ..  1  0  9  
• Received transfusion of blood/blood components (other than clotting factor) .....  1  0  9  
• Received transplant of tissue/organs or artificial insemination .....  1  0  9  
**Before the diagnosis of HIV Infection/AIDS, this child had:** Yes No Unk.  
• Received clotting factor for hemophilia/coagulation disorder .....  1  0  9  
(specify:  1 Factor VIII (Hemophilia A)  2 Factor IX (Hemophilia B) disorder):  8 Other (specify): \_\_\_\_\_  
• Received transfusion of blood/blood components (other than clotting factor) .....  1  0  9  
First: Mo. Yr. [ ][ ] [ ][ ] Last: Mo. Yr. [ ][ ] [ ][ ]  
• Received transplant of tissue/organs .....  1  0  9  
• Sexual contact with a male .....  1  0  9  
• Sexual contact with a female .....  1  0  9  
• Injected nonprescription drugs .....  1  0  9  
• Other (Alert State/City NIR Coordinator) .....  1  0  9

**VI. STATE/LOCAL USE ONLY**

Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Medical Record No. \_\_\_\_\_  
 (Last, First, M.I.)  
 Hospital/Facility: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
**- Physician identifier information is not transmitted to CDC! -**

**VII. LABORATORY DATA**

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

	Positive	Negative	Indeterminate	Not Done	TEST DATE	
					Mo.	Yr.
• HIV-1 EIA .....	1	0	-	9		
• HIV-1 EIA .....	1	0	-	9		
• HIV-1/HIV-2 combination EIA .....	1	0	-	9		
• HIV-1/HIV-2 combination EIA .....	1	0	-	9		
• HIV-1 Western blot/IFA .....	1	0	8	9		
• HIV-1 Western blot/IFA .....	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

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

	Positive	Negative	Not Done	TEST DATE		
				Mo.	Yr.	
• HIV DNA PCR .....	1	0	9			• HIV DNA PCR .....
• HIV DNA PCR .....	1	0	9			• HIV RNA PCR .....
• HIV RNA PCR .....	1	0	9			• HIV RNA PCR .....
• HIV RNA PCR .....	1	0	9			• Other, specify _____
• HIV antigen test .....	1	0	9			
• HIV antigen test .....	1	0	9			

**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		Test type*	Detectable		Copies/ml	Test Date	
	Yes	No		Mo.	Yr.		Yes	No		Mo.	Yr.
	1	0					1	0			

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

	Mo.	Yr.
• CD4 Count .....		
• CD4 Count .....		
• CD4 Percent .....		
• CD4 Percent .....		

**5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? .....** Yes No Unk.

**6. If laboratory tests were not documented, is patient confirmed by a physician as:** Yes No Unk. Date of Documentation

	Yes	No	Unk.	Mo.	Yr.
• HIV-infected .....	1	0	9		
• Not HIV-infected .....	1	0	9		

**VIII. CLINICAL STATUS**

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

Def. = definitive diagnosis Pres. = presumptive diagnosis

**Has this child been diagnosed with pulmonary tuberculosis?\***  Yes  No  Unk. If yes, initial diagnosis and date:  Definitive  Presumptive

Mo. Yr. \*RVCT CASE NO.:

**IX. BIRTH HISTORY (for PERINATAL cases only)**

Birth history was available for this child:  1 Yes  0 No  9 Unk. *If No or Unknown, proceed to Section X.*

**HOSPITAL AT BIRTH:**

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**RESIDENCE AT BIRTH:**

City: \_\_\_\_\_ County: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code:

**BIRTHWEIGHT:**

(enter lbs/oz OR grams)

lbs.   oz

grams

**BIRTH:** Type: ....  1 Single  2 Twin  3 >2  9 Unk.

**Delivery:** .....  1 Vaginal  2 Elective Caesarean  3 Non-elective Caesarean  
 4 Caesarean, unk. type  9 Unk.

**Birth Defects:** ....  1 Yes  0 No  9 Unk.  
Specify type(s): \_\_\_\_\_ Code:

**NEONATAL STATUS:**

1 Full term

2 Premature

Weeks     
99 = Unk.

**PRENATAL CARE:**

Month of pregnancy prenatal care began:   mos.  
99 = Unk.  
00 = None

Total number of prenatal care visits:    
99 = Unk.  
00 = None

• Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused Yes No Unk.  
 8  1  0  9

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

• If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks:     
99 = Unk.

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

• Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unk.  
 1  0  9  
If yes, specify: \_\_\_\_\_

• Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unk.  
 1  0  9  
If yes, specify: \_\_\_\_\_

**Maternal Date of Birth**

Mo. Day Yr.

**Maternal Soundex:**

**Maternal State Patient No.**

**Birthplace of Biologic Mother:**

1 U.S.  7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): \_\_\_\_\_  
 8 Other (specify): \_\_\_\_\_  9 Unk.

**X. TREATMENT/SERVICES REFERRALS**

**This child received or is receiving:**

• Neonatal zidovudine (ZDV, AZT) for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.  
 1  0  9

• Other neonatal anti-retroviral medication for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.  
 1  0  9

If yes, specify: \_\_\_\_\_

• Anti-retroviral therapy for HIV treatment Yes No Unk. DATE STARTED Mo. Day Yr.  
 1  0  9

• PCP prophylaxis Yes No Unk. DATE STARTED Mo. Day Yr.  
 1  0  9

**Was child breastfed?**

Yes No Unk.  
 1  0  9

**This child has been enrolled at:**

**Clinical Trial** **Clinic**  
 1 NIH-sponsored  2 Other  1 HRSA-sponsored  2 Other  
 3 None  9 Unk.  3 None  9 Unk.

**This child's medical treatment is primarily reimbursed by:**

1 Medicaid  4 Other Public Funding  
 2 Private insurance/HMO  7 Clinical trial/government program  
 3 No coverage  9 Unk.

**This child's primary caretaker is:**

1 Biologic parent(s)  2 Other relative  3 Foster/Adoptive parent, relative  4 Foster/Adoptive parent, unrelated  7 Social service agency  8 Other (specify in Section XI.)  9 Unk.

**XI. COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(XI. COMMENTS CONTINUED ON THE BACK)*

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). **Do not send the completed form to this address.**

XI. COMMENTS (continued)

Lined area for writing comments, consisting of multiple horizontal lines and a vertical margin line on the left side.