California Department of Public Health
Office of AIDS
HIV/AIDS Surveillance Program

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≤ 12 years of age at time of diagnosis)

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

Patient's name (last, first, MI) | Telephone number ( ) | Social Security Number

Address (number, street) | City | County | State | ZIP code

Date form completed (mm/dd/yyyy) Month Day Year | Report status: 1 New, 2 Update

II. *Health Department Use Only*

Report source | Reporting health department | State patient number | City/county patient number

Soundex code | Date of birth (mm/dd/yyyy) Month Day Year | Gender: 1 Male, 2 Female | CLIA number | Lab report/Accession number | *Confidential C&T number

*Publicly funded confidential counseling and testing sites only

III. Demographic Information

Diagnosis status at report (check one) | Age at Diagnosis Years Months
- 3 Perinatally HIV exposed
- 4 Confirmed HIV infection (not AIDS)
- 5 AIDS
- 6 Seroreverter

Current status: 1 Alive, 2 Dead, 9 Unknown | Date of death Month Day Year

State/Territory of death

Date of initial evaluation for HIV infection Month Day Year

Was reason for initial HIV evaluation due to clinical signs and symptoms? 1 Yes, 0 No, 9 Unknown

Date of last medical evaluation Month Day Year

ETHNICITY
- 1 Hispanic
- 2 Not Hispanic nor Latino

RACE
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Black or African American
- Asian
- White
- Unknown

COUNTRY OF BIRTH
- 1 U.S.
- 9 Unknown
- 7 U.S. Territories (including Puerto Rico)
- 8 Other (specify):_____

Expanded race (specify):_____

☐ Check here if HIV infection is presumed to have been acquired outside United States and Territories. Specify country:_____

Residence at first diagnosis of HIV or AIDS: ☐ Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.)

City | County | State/Country | ZIP code

IV. Facility of Diagnosis

Facility name | City | State/Country

Facility setting (check one)
- 1 Public
- 3 Federal
- 2 Private
- 9 Unknown

Facility type (check one)
- 01 Physician, HMO
- 29 Community Health Center
- 31 Hospital, inpatient
- 88 Other (specify):_____
- 22 Counseling and Testing Site
- 30 Correctional Facility
- 32 Hospital, outpatient
- 99 Unknown

V. Patient/Maternal Risk History (Respond to all categories.)

Child's biological ***mother's*** HIV infection status (check one)

HIV negative or no diagnosis:
- 1 Refused HIV testing
- 2 Known to be **uninfected** after this child's birth **(Alert city/county HIV/AIDS Surveillance)**
- 9 HIV status unknown

HIV positive or AIDS diagnosis:
- 3 Before pregnancy with this child
- 4 During pregnancy with this child
- 5 At the time of delivery
- 6 Before the child's birth, exact period unknown
- 7 After the child's birth
- 8 HIV-infected, unknown when diagnosed

Date of ***mother's*** first positive HIV confirmatory test: Month Year

Mother was counseled about HIV testing during this pregnancy, labor, or delivery: Yes 1 | No 0 | Unknown 9

Before the diagnosis of HIV/AIDS, this child's biological *mother* had:

	Yes	No	Unknown
• 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
• Male with perinatally-acquired HIV	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
• Perinatally-aquired HIV infection, regardless of mother's date of birth	1	0	9

Before the diagnosis of HIV infection/AIDS, this *child* had:

	Yes	No	Unknown
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

(Specify disorder): 1 Factor VIII (Hemophilia A), 2 Factor IX (Hemophilia B), 8 Other (specify):_____

	Yes	No	Unknown
• Received transfusion of blood/components (other than clotting factor)	1	0	9

First: Month Year | Last: Month Year

	Yes	No	Unknown
• 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. Provider Information

Physician's name (last, first, MI)	Patient's medical record number	Person completing form	Physician's Telephone Number ( )
Address (number, street)		City	State / ZIP code

VII. Laboratory Data (Indicate the first positive test.)

1. HIV Antibody tests at initial diagnosis (Record all tests, include earliest positive.):

	Positive	Negative	Indeterminate	Not done	Test Date Month	Day	Year
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 Month	Day	Year
HIV culture	1	0	9			
HIV culture	1	0	9			
HIV antigen test	1	0	9			
HIV antigen test	1	0	9			

	Positive	Negative	Not done	Test Date Month	Day	Year
HIV DNA PCR	1	0	9			
HIV DNA PCR	1	0	9			
HIV RNA PCR	1	0	9			
HIV RNA PCR	1	0	9			
Other, (specify) _____	1	0	9			

3. **HIV Viral Load Test** *(Record earliest test.)* Month Day Year

Test type*: ☐☐ Version*: ☐☐ ☐☐☐☐☐☐☐☐

Other (specify type and version): _____

Test result *(Record in copies/mL **and** log_{10} values.)*

☐ Detectable — Copies/mL: ☐,☐☐☐,☐☐☐

Log_{10}: ☐☐.☐☐

Greater than: ☐,☐☐☐,☐☐☐ copies/mL

☐ Undetectable — Less than: ☐☐☐ copies/mL

* Test type and version: 11 = NucliSens® HIV-1 QT (Organon-NASBA)
12 = Amplicor HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5
13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0
18 = Other (kit name/manufacturer/version) _____

4. Immunologic Lab Tests (At or closest to current diagnostic status.) Month Day Year

CD4 count ☐,☐☐☐ cells/µl ☐☐☐☐☐☐

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	Unknown
1	0	9

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unknown	Date of Documentation Month	Day	Year
HIV-infected	1	0	9			
Not HIV-infected	1	0	9			

VIII. Clinical Status (Def. = Definitive diagnosis / Pres. = Presumptive diagnosis)

AIDS Indicator Diseases	Initial Diagnosis Def.	Pres.	Initial Date Month	Year
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 month duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 month of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA		

AIDS Indicator Diseases	Initial Diagnosis Def.	Pres.	Initial Date Month	Year
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis jirovecí pneumonia (PCP)	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 month of age	1	2		
Wasting syndrome due to HIV	1	NA		

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unknown

If yes, initial diagnosis: 1 Definitive 2 Presumptive Date: Month Year

*RVCT case number

IX. Birth History (For *PERINATAL* cases only.)

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

	Name of hospital	Address (number, street)	City	County	State	ZIP code	Country
Hospital at birth:							

	City	County	State	ZIP code	Country
Residence at birth:					

Birth weight (enter lbs/oz *or* grams)
[ ][ ] lbs. [ ][ ] oz.
[ ][ ][ ][ ] grams

Birth Type: [1] Single [2] Twin [3] >2 [9] Unknown

Delivery: [1] Vaginal [2] Elective Caesarean [3] Nonelective Caesarean [4] Caesarean, unknown type [9] Unknown

Birth defects: [1] Yes [0] No [9] Unknown
Specify type(s):_____ Code: [ ][ ][ ].[ ][ ][ ]

Neonatal status: (99 = Unknown)
[1] Full term
[2] Premature
[ ][ ] weeks

Prenatal Care (99 = Unknown/00 = None)
Month of pregnancy prenatal care began: [ ][ ] Months
Total number of prenatal care visits: [ ][ ]

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

If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? (99 = Unknown)..... [ ][ ] weeks

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

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

	Yes	No	Unknown
Did mother receive any other anti-retroviral during pregnancy?	1	0	9

If yes, specify:_____

	Yes	No	Unknown
Did mother receive any other anti-retroviral medication during labor/delivery?	1	0	9

If yes, specify:_____

Biological Mother's date of birth Month Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ]

Biological Mother's Soundex [ ][ ][ ][ ] _____

Biological Mother's State Patient Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Birthplace of biological mother

[1] U.S. [7] U.S. Territories (including Puerto Rico) (specify):_____

[8] Other (specify):_____ [9] Unknown

X. Treatment/Services Referrals

This child received or is receiving:

	Yes	No	Unknown	DATE STARTED Month	Day	Year
Neonatal zidovudine (ZDV, AZT) for HIV prevention.....	1	0	9			
Other neonatal anti-retroviral medication for HIV prevention.....	1	0	9			

If yes, specify:_____

	Yes	No	Unknown	DATE STARTED Month	Day	Year
Anti-retroviral therapy for HIV treatment.....	1	0	9			
PCP prophylaxis.....	1	0	9			

Was child breastfed?

Yes	No	Unknown
1	0	9

This child has been enrolled at:

Clinical trial
[1] NIH-sponsored [2] Other [3] None [9] Unknown

Clinic
[1] HRSA-sponsored [2] Other [3] None [9] Unknown

This child's medical treatment is primarily reimbursed by
[1] Medicaid [2] Private insurance/HMO [3] No coverage [4] Other public funding [7] Clinical trial/government program [9] Unknown

This child's primary caretaker is:
[1] Biological 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] Unknown

XI. Comments

MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
LHD contact information is available on the website: www.cdph.ca.gov/AIDS

XI. Comments (continued)

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