Alternate Name Type (example: Bilth, Call Me)	<b>Patient Identification (rec</b>	ord all date	s as mn	n/dd/y	ууу)									
Address Type   Realdential   Bad address   Correctional facility   Country   State/Country   ZIP Code							*Last	*Last Name			Last Name Soundex			
Pote   City   County   State/Country   ZIP Code	Alternate Name Type (example: Birth, Call Me)		*F	First Name			*Middle	*Middle Name		*Last Name				
Medical Record Number	☐ Foster home ☐ Homeless ☐ Military □			orial lability		dress, Stree	es, Street			Address Date				
U.S. Department of Health and furnish services    Pediatric HIV Confidential Case Report Form   Centers for Disease Control and Prevention (CRC)   Centers for Disease Control and Prevention (CRC)   CRC	*Phone Ci	Phone City			County			State/Country			*ZIP Code			
Realth Department Use Office (Patients aged <13 years at time of diagnosis) "information NOT transmitted to CDC   Market Pearl Health Department   State Number   State N	*Medical Record Number		*Other ID Type				*Number							
State Number   City/County N										ос				
Reporting Health Dept—City/County    City/County Number   City/County Number								F			o. 0920-0573 Exp. 11/30/2022			
Doument Source   Surveillance Method   Report Medition   Passive   Pollow up   Reabstraction   Unknown   Report Medition   Passive   Pollow up   Reabstraction   Unknown   Report Medition   Passive   Report Medition   Phone   Phone   Phone   Phone   Phone   Phone   Phone   Report Medition   Phone   Pho		nent		eHARS	Docume	ent UID		State N			lumber			
Active   Passive   Follow up   Reabstraction   Unknown														
Pacility Providing Information (record all dates as mm/dd/yyyy)   Facility Name	Document Source													
Facility Name		se investigation		Report Medium										
**Street Address**  City	Facility Providing Informa	ation (recor	rd all da	tes as	mm/dd	/уууу)								
City   County   State/Country   *ZIP Code   Facility   Inpatient:   Hospital   Outpatient:   Private physician's office   Pediatric clinic   Other, specify   Unknown   Other, specify							*Phone	*Phone						
Facility   Inpelient:   Hospital   Outpetient:   Private physician's office   Pediatric clinic   Other, specify   Date Form Completed   Pediatric HIV clinic   Other, specify   Unknown   Other, specify   Unknown   Other, specify   Other, specify   Other   Pediatric HIV clinic   Other, specify	*Street Address													
Type   Other, specify   Pediatric HIV clinic   Other, specify   Other, spe	City	County				State/Country				*ZIP Code				
Patient Demographics (record all dates as mm/dd/yyyy)   Diagnostic Status at Report   3-Perinatal HIV exposure   Sex Assigned at Birth   Gountry of   US   Other/US dependency   4-Pediatric HIV   5-Pediatric AlDS   6-Pediatric seroreverter   Male   Female   Unknown   Birth   (please specify)   Date of Birth   /   /														
Diagnostic Status at Report   3-Perinatal HIV exposure   A-Pediatric HIV   5-Pediatric AIDS   6-Pediatric seroreverter   Alias Date of Birth   /														
display   Date of Birth	Patient Demographics (re	cord all dat	es as m	m/dd/	уууу)									
Vital Status   1-Alive   2-Dead   Date of Death  / _   Date of Initial Evaluation for HIV  /														
Date of Last Medical Evaluation	Date of Birth / /													
Ethnicity   Hispanic/Latino   Not Hispanic/Latino   Unknown   Expanded Ethnicity    Race   American Indian/Alaska Native   Asian   Black/African American   (check all that apply)   Native Hawaiian/Other Pacific Islander   White   Unknown    Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)  Address Event Type   Residence at HIV   Residence at stage   Residence at   Residence at   Check if SAME as (check all that apply to address below)   diagnosis   3 (AIDS) diagnosis   perinatal exposure   pediatric seroreverter   current address    Address Type   Residential   Bad address   Correctional facility   Foster home   Homeless   Military   Other   Postal   Shelter   Temporary    *Street Address    City   County   State/Country    *ZIP Code    Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.	Vital Status   1-Alive   2-Dead   Date of Death  //  State of Death													
Race   American Indian/Alaska Native   Asian   Black/African American (check all that apply)   Native Hawaiian/Other Pacific Islander   White   Unknown   Unknown    Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)  Address Event Type   Residence at HIV   Residence at stage   Residence at   Residence at   Check if SAME as (check all that apply to address below)   diagnosis   3 (AIDS) diagnosis   perinatal exposure   pediatric seroreverter   current address    Address Type   Residential   Bad address   Correctional facility   Foster home   Homeless   Military   Other   Postal   Shelter   Temporary    *Street Address  City   County   State/Country   *ZIP Code    Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.	Date of Last Medical Evaluation//Date of Initial Evaluation for HIV//													
Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)  Address Event Type	Ethnicity   Hispanic/Latino   Not Hispanic/Latino   Unknown   Expanded Ethnicity													
Address Event Type	'													
Address Event Type	Residence at Diagnosis (a	add additior	nal addr	esses	in Com	ments)	(record all	dates as n	nm/dd/yyy	v)				
*Street Address  City  County  State/Country  *ZIP Code  Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.	• • • • • • • • • • • • • • • • • • • •			HIV			•							
Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). Do not send the completed form to this address.	Address Type   Residential	Bad address	□ Correct	tional fa	cility $\square$ F	oster hon	ne 🗆 Home	less   Milita	ry □ Othei	r 🗆 Pos	tal □ Shelter □ Temporary			
Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). <b>Do not send the completed form to this address.</b>	*Street Address													
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This report to 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	existing data sources, gathering a sponsor, and a person is not requ regarding this burden estimate or Officer, 1600 Clifton Road, MS D-	and maintaining uired to respond any other aspondary, Atlanta, G. by law (Section	g the data d to, a co ect of this A 30333, ns 304 ar	neede llection collect ATTN:	ed, and co of inform tion of info PRA (092 of the Put	mpleting ation unlearmation, 20-0573).	and reviewings it displays including support the not sender.	ng the collections a currently was a currently was ggestions for a december the complexity of the collections are considered as a collection of the collections are collected as a collection of the collection of	on of informalid OMB coreducing this ted form to be and 242k)	ation. An ontrol nurs burden, this add	agency may not conduct or mber. Send comments , to CDC, Project Clearance dress.			

for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV 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).

STATE/LOCA												
*Provider Name (Last, First, M.I.)								e (	)			
Hospital/Facility	,											
Facility of Dia	hhe) sisonna	additio	nal facilities	in Com	ments)							
Diagnosis Type	<u> </u>					S) □ Perin	atal exposure	□ Check if	SAMF as fa	cility pro	vidin	g information
	(61.0011 011 01 01)	,, 10										9
Facility Name								*Phoi	ne ( )			
*Street Address												
City		Co	unty			State/Coun	itry		*ZIP Cod	е		
Facility Type										☐ Laboratory		
*Provider Name				*P	rovider Phor	ne ( )		Specia	lty			
Patient Histor	ry (respond to	all au	estions) (rec	ord all	datas as mi	m/dd/\nnn/						
Child's biological r								after this ch	ild's hirth			
☐ Known HIV+ be			,			0						
☐ Known HIV+ aft	er child's birth	HIV+, ti	me of diagnosis	unknown								
Date of mother's f	first positive test to	o confirm	n infection	, ,			logical mother c ivery? □ Yes			sting duri	ng th	is pregnancy,
After 1977 and be									OTKHOWIT			
Perinatally acquire			anagnoon on i						□Ye	s □ No	П	Unknown
Injected nonpresc									□Ye			Unknown
<u> </u>		EXUAL	relations with	any of th	ne following:							<u> </u>
Biological mother had HETEROSEXUAL relations with any of the following:  HETEROSEXUAL contact with intravenous/injection drug user								□Ye	s □ No		Unknown	
HETEROSEXUAL contact with bisexual male								□ Ye	s □ No		Unknown	
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection								□ Ye	s □ No		Unknown	
HETEROSEXUAL contact with transfusion recipient with documented HIV infection								□ Ye	s □ No		Unknown	
HETEROSEXUAL contact with transplant recipient with documented HIV infection								□ Ye	s □ No		Unknown	
								Unknown				
Biological mothe	er had:											
Received transfus	sion of blood/blood	d compo	nents (other tha	an clotting	g factor) (docu	ument reaso	n in Comments)		□ Ye	s □ No		Unknown
First date received// Last date received//												
Received transpla				on					□ Ye	s 🗆 No		Unknown
Before the diagno		on, this	child had:						V	- 11		
Injected nonprescription drugs								□ Ye			Unknown	
Received clotting factor for hemophilia/coagulation disorder  Specify clotting factor:  Date received///								□Ye	s 🗆 No	) [	Unknown	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)								□Ye	s □ No		Unknown	
First date received / / Last date received / /												
Received transplant of tissue/organs								□ Ye	s □ No		Unknown	
Sexual contact with male								□ Ye	s □ No		Unknown	
Sexual contact with female								□ Ye	s □ No		Unknown	
Other documented risk (please include detail in Comments)												
Clinical: Oppo	ortunistic IIIn	esses	(record all	dates a	s mm/dd/yy	уу)						
Diagnosis		Dx Date	Diagn	osis			Dx Date	Diagnosis				Dx Date
Bacterial infection, mu			HIV end	cephalopatl	ny				um avium com			
(including Salmonella Candidiasis, bronchi, t			Herpes	simplex: cl	nronic ulcers (>1	mo. duration),			seminated or e sis, pulmonary	4	nary	
			bronchi	tis, pneumo	onitis, or esophaç	gitis						
Candidiasis, esophage	eal		Histopia	asmosis, di	sseminated or ex	ktrapulmonary		or extrapulm	sis, dissemina onary <sup>1</sup>	ted		
Carcinoma, invasive o	cervical		Isospor	iasis, chror	nic intestinal (>1 ı	mo. duration)			um, of other/ur			
Coccidioidomycosis, d	disseminated		Kaposi'	s sarcoma					eminated or e	xtrapulmon	ary	
or extrapulmonary								-				
Cryptococcosis, extra	pulmonary		1 .	oid interstiti ary lympho	al pneumonia an id	u/Of		rneumonia,	recurrent in 12	mo. perio	u	
(>1 mo. duration)												
Cytomegalovirus disea (other than in liver, spl			Lympho	oma, immui	noblastic (or equi	ivalent)		Toxoplasmos of age	sis of brain, on	set at >1 m	10.	
Cytomegalovirus retin	· · · · · · · · · · · · · · · · · · ·		Lympho	oma, prima	ry in brain				drome due to I	HIV		
of vision)  1If a diagnosis date is	entered for either tube	erculosis o	diagnosis above pr	ovide RVC	T Case Number							
	IOI OILIIOI LUDO		gc.io above, pi		. Caso Hallibel.							

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

Laboratory Data (record additional tests and tests not specified	below in Comments, (record an dates as initidally yyy)
HIV Immunoassays (Nondifferentiating)	
TEST 1 □ HIV-1 IA □ HIV-1/2 IA □ HIV-1/2 Ag/Ab □ HIV-1 WB □ HIV-1 IF	FA 🗆 HIV-2 IA 🗆 HIV-2 WB
Test brand name/Manufacturer	Lab name
Facility name	Provider name
Result □ Positive □ Negative □ Indeterminate	Collection Date/ Doint-of-care rapid test
TEST 2 - HIV-1 IA - HIV-1/2 IA - HIV-1/2 Ag/Ab - HIV-1 WB - HIV-1 IF	
Test brand name/Manufacturer	Lab name
Facility name	Provider name
Result □ Positive □ Negative □ Indeterminate	Collection Date/ Doint-of-care rapid test
HIV Immunoassays (Differentiating)	onocion bato = 1 cint of care rapid tool
☐ HIV-1/2 type-differentiating immunoassay	Role of test in diagnostic algorithm
(differentiates between HIV-1 Ab and HIV-2 Ab)	□ Screening/initial test □ Confirmatory/supplemental test
Facility name	Lab name
Facility name	itive untynable   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
	<sup>1</sup> Always complete the overall interpretation. Complete the analyte results when available.
☐ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag	
Test brand name/Manufacturer	
	Provider name
Result □ Ag positive □ Ab positive □ Both (Ag and Ab positive) □ Negative	
Collection Date / Doint-of-care rapid test	7 LIIV ( 1 Ag LIIV ( 1 Ab and LIIV ( 2 Ab)
☐ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among	
Test brand name/Manufacturer	Lab name
Facility name	
<b>Result<sup>2</sup> Overall interpretation</b> : □ Reactive □ Nonreactive □ <b>Index value</b> _	
Analyte results: HIV-1 Ag: □ Reactive □ Nonreactive □ Not report	able due to high Ab level Index value
HIV-1 Ab: □ Reactive □ Nonreactive □ Reactive υ	undifferentiated Index value
HIV-2 Ab: □ Reactive □ Nonreactive □ Reactive υ	
Collection Date// Doint-of-care rapid test	<sup>2</sup> 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/E	DNA NAAT (Qualitative) □ HIV-2 culture
Test brand name/Manufacturer	Lab name
Facility name	
Result □ Positive □ Negative □ Indeterminate	Collection Date / /
HIV Detection Tests (Quantitative viral load) Note: Include earliest test at	
TEST 1 □ HIV-1 RNA/DNA NAAT (Quantitative viral load) □ HIV-2 RNA/DNA	
Test brand name/Manufacturer	
	Provider name
Result   Detectable Undetectable Copies/mL	Collection Date
TEST 2   HIV-1 RNA/DNA NAAT (Quantitative viral load)   HIV-2 RNA/DNA	Log Collection Date//
Test brand name/Manufacturer	Lab name
Facility name	
Result   Detectable Undetectable Copies/mL	Log Collection Date//
Drug Resistance Tests (Genotypic)	
TEST □ HIV-1 Genotype (Unspecified)	
Test brand name/Manufacturer	
Facility name	Provider name
Collection Date / / /	
Immunologic Tests (CD4 count and percentage)	
CD4 at or closest to diagnosis: CD4 count cells/uL	CD4 percentage % Collection Date / /
Test brand name/Manufacturer	
Facility name	Provider name
	Provider name
	CD4 percentage % Collection Date//
Test brand name/Manufacturer	
Facility name	Provider name
	CD4 percentage % Collection Date / /
Test brand name/Manufacturer	Lab name
	Provider name
Documentation of Tests	
Did documented laboratory test results meet approved HIV diagnostic algo	rithm criteria?  Ves  No  Inknown
If YES, provide specimen collection date of earliest positive test for this alg	
Complete the above only if none of the following were positive for HIV-1: Western	
differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nu	
	es    No    Unknown Date of diagnosis//
is patient confirmed by a physician as Not HIV-infected 🗆 Yo	es 🗆 No 🗅 Unknown Date of diagnosis / / / /

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## **Birth History** (for Perinatal Cases only) Birth history available? ☐ Yes ☐ No ☐ Unknown Residence at Birth ☐ Check if SAME as current address Address Type Residential Bad address Correctional facility Foster home Homeless Military Other Postal Shelter Temporary \*Street Address City \*ZIP Code County State/Country Facility of Birth □ Check if SAME as facility providing information **Facility Name of Birth** \*Phone (if child was born at home, enter "home birth") Facility Type *Inpatient:* □ Hospital Other Facility: ☐ Emergency room ☐ Corrections ☐ Unknown Outpatient: ☐ Other, specify ☐ Other, specify □ Other, specify Citv \*Street Address \*ZIP Code County State/Country Type □ 1-Single □ 2-Twin □ 3-More than two **Birth History** Birth Weight lbs ΟZ grams □ 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—Total Number of Prenatal Care Visits Prenatal Care—Month of Pregnancy Prenatal Care Began (99 = Unknown, 00 = None) (99 = Unknown, 00 = None) Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? If yes, specify all ARVs ☐ Yes ☐ No ☐ Refused ☐ Unknown Date of last use \_\_/\_\_ Date began \_ If yes, specify all ARVs Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown Date began \_\_/\_\_ Date of last use Did mother receive any ARVs during labor/delivery? If yes, specify all ARVs ☐ Yes ☐ No ☐ Refused ☐ Unknown Date began \_ Date of last use / **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) Date began \_\_ /\_\_ /\_\_ /\_\_ \_\_ \_\_ Date of last use \_\_ \_ /\_\_ \_ /\_\_ \_\_ \_\_\_ ☐ HIV Tx ARV medications Date began \_\_\_ /\_\_ /\_\_ /\_\_ \_\_ Date of last use \_\_ \_/\_\_ /\_\_ /\_\_ \_\_\_ □ PrEP ARV medications □ PEP ARV medications Date began / / Date of last use / / □ PMTCT ARV medications \_\_\_ Date began \_\_\_ /\_\_ /\_\_ /\_\_ \_\_\_ Date of last use \_\_ \_ /\_\_ \_ /\_\_ \_\_ Date began \_\_\_ /\_\_ /\_\_ /\_\_ \_\_ \_\_ Date of last use \_\_ \_/\_\_ /\_\_ \_\_\_ □ HBV Tx ARV medications □ Other (specify reason)\_ Date of last use \_\_\_ ARV medications Date began \_\_\_ Date of last use Has this child ever taken PCP prophylaxis ☐ Yes ☐ No ☐ Unknown Date began \_\_\_ 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** Local/Optional Fields

Rev 11/2019

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