PATIENT INFORMATION								Talact -	o Number (`				
Patient's Name:							relephon		ZIP					
Address:		ty:			_ County:			State:		Code: _		to CDCI		
* This agency is requesting disclosure of your Socail Securi		Social Sectordance with I	_		oluntary and you	will not be			ıyıcı injormal	wn is not t	иньтинеа	O CDC! -		
PERINATAL EXPOSISTANT STATE DEPARTMENT OF THE PROPERTY OF T			ΓIAL RI	EPORT			_							
DATE FORM COMPLETED:		REPORT S	TATUS:					State Pati	ent Number:	:				
Month Day Year									1 1	1 1	1 1			
II. DIAGNOSTIC INFORMATION			ew Report											
	<u> </u>			fected with F	PORT FOR CHILDREN BORN TO MOTHERS WITH HIV INFECTION (If child is confirmed HIV Infected please use State Form 51202.) State Patient Number:									
DATE OF BIRTH: Month Day Year	SEX : 1 N	IALE 2 F	EMALE											
	CURRENT ST	ATUS:	1 Alive	2 Dead	3 Unk.	RACE (S	elect one o	or more):						
Was reason for initial HIV evaluation due to	ETHNICITY (s	elect one):				Americ	an Indiana	a or Alaska Native Asian Black or African American						
clinical signs and symptoms?					no 9 Unk	Native	Hawaiian/o	r Other Pacific	slander	☐ Wh	ite 🗌	Unknown		
1 0 9						COLINTO	V OE DIDT	u . 11 11 e	8 Other /a=	aciful:				
						COUNTR	OF BIKI	π. ∐ ∪.δ.	o Jourier (spe	ыу)				
INFECTION: Month Day Year	INFECTION:	Month	Dav	Year										
II. PATIENT/MATERNAL HISTORY (Respon	nd to ALL ca	tegories.)												
· · · ·		<u> </u>	Diale!	mather - "	annes de de la la	JIV 1mfr - 1	m/AIDC							
* Child's biologic mother's HIV infection status (cneck one):				_	nv intectio	m/AIDS:		01					
1 Refused HIV testing	ore this chil	d's pregnancy			6 Befo	ore Child's birth	i, exact perio	d unknown						
2 Known to be <u>uninfected</u> after this child's birth	own to be <u>ur</u>	ninfected after t	nis child's b	irth	er the child's birt	th								
9 HIV status unknown			5 At t	ime of deliv	ery			8 HIV	-infected, unkno	own when d	agnosed			
*Date of mother's first positive HIV confirmatory		n Yea	ır						· .					
After 1077, this shild's historie mether had		Voc. No.												
Injected nonprescription drugs	STATE PROKET													
HETEROSEXUAL relations with:		1 0			8 Other (s	pecify):								
			= .	Received tra	ansfusion of blo	od/blood co	mponents			Yes	No	Unk.		
			<u> </u>		clotting factor):		,	M	V	1	0	9		
				First:	Month	Year	Last:			Yes	No	Unk.		
- Transplant recipient with documented HIV infection				Received tra	ansplant of tissu	e/organs								
- Male with AIDS or documented HIV infection, risk no				Sexual cont	act with a male				9					
	·			Sexual cont	act with a femal	e				1	0	9		
(other than clotting factor)			ا	njected nor	prescription dru	ıgs				1	0	9		
Received transplant of tissue/organs or artificial insen	nination	1 0	9 (Other (Alert	State Health De	epartment)				1	0	9		
V. LABORATORY DATA														
							Inde	terminate		-				
								- R		_				
					ــــــــــــــــــــــــــــــــــــــ	U		Ů	_ <u>a</u>					
2. HIV DETECTION TESTS: (Record all tests, include earliest positive.)		Net	T	T DATE						N	ot	TEST DATE		
Positive HIV culture	Negative 0				• HIV DN	A PCR				ve <u>Do</u>	ne			
■ HIV antigen test	0	9			• HIV RN	A PCR		1	0		9			
3. HIV VIRAL LOAD TEST: (Record all tests, include	le earliest detec	ctable.)			*Test type:	11. NASE	BA (Organor	n) 12. R	T-PCR (Roche)) 13. t	DNA (Chiro	n) 18. Other		
Toutend Division			Test Dat		_		D-4 - 1 - 1	_	0					
Test type* Detectable C Yes No 1 0	opies/ml		onth	Year	Tes		Yes N	lo	Copies/ml		Month	Year		
4. IMMUNOLOGIC LAB TESTS: (At or closest to c	urrent diaanost	ic status)			5. If laborat	ory tests we			ient confirmed	by a physici	an as:	. ———		
]	2aborat	. ,		10 pai	20	. , p., yololi		ocumentation		
CD4 Count , , , , , , , , , , , , , , , ,	cells/μL			J			Yes	1 -	No					
CD4 Percent	%				Not HIV-i	nfected	1	<u> </u>	0	9	Щ_			

V. BIRTH HISTORY (Fo	_	POSURES only.) 1 Yes 0 No* 9 Unk.		*If No or Unknown, pro	oceed to Sect	ion VI.							
HOSPITAL AT BIRTH:													
Hospital:			City:		State:				_ Country	y:			
RESIDENCE AT BIRTH:			0		710								
City:	County:		State/ Country	r:	ZIP Code:					· <u> </u>			
BIRTHWEIGHT:	BIRTH:				NEON	ATAL ST	ATUS:	PREN	ATAL CARE				
(enter lbs/oz OR grams)	TYPE:	1 Single 2 Twin 3 >2	9 U	nk.	1	Full term			of pregnancy	y [Month	99=Unk.	
lbs. oz.	DELIVERY:	1 Vaginal 2 Elective	2 Non-	elective	2	Prematu	е	prenata	al care begai	n:		00=None	
grams	DELIVERY:	1 Vaginal 2 Caesarean	³ Caes	arean	Wee				number of al care visits:			99=Unk. 00=None	
		4 Caesarean, Unk. type	9 Unk.		(99=	=Unk.)							
	BIRTH DEFEC	TS: 1 Yes 0 No	9 U	nk.									
	Specify type(s)	: Code:											
DID MOTHER RECEIVE ZID	OVUDINE (ZDV, AZ	Γ)?											
		sed 8 Unk. 9 If Yes, what w	eek					1	or State				
During labor/delivery? You		_ _						I M	1CHD	LCHD	Ot	ther	
Prior to this pregnancy? Ye								Su	ırv. Coord. in	itials			
		dication during pregnancy? Yes	1 No	0 Unk. 9 If ves. specif	fv:			-	llow-up date				
		dication during labor/delivery? Ye					_	Fo	llow-up plan				
VI. INFORMATION ON N													_
Maternal Date of Birth				Materna Sounde		Materna	I State P	atient N	umber				
Month Day	Year	(Mother's Name)		Gourne.	<u>^.</u>								
		(Father's Name)				<u> </u>			1 1	l .	<u> </u>	1	
	Father	's HIV Status (check one):	Positiv	e 0 Negative	9 Unk.								
Birthplace of Biologic Mot	ther:												_
1 U.S. 7	U.S. Dependencies a	and Possessions (including Puerto Ric	co) (speci	fy):									
8 Other (specify):						9	Unk.						
VII. TREATMENT/SERV		6	1	1									_
This child received or is rec	-	DATE STARTED nk. Month Day Ye	ear	Was child breastfed?	This child	has beer	enrolled	l at:	This child's primarily re			nent is	
 Neonatal zidovudine (ZDV, AZT) for HIV 	1 0 9	- 		Yes No Unk.	Clinical Tr	<u>ial</u>			1 Med	dicaid			
prevention				1 0 9	1 NIH-sp	onsored	2 0	ther	2 Priv	ate insu	ırance/H	IMO	
 Anti-retroviral therapy for HIV treatment 	1 0 9		Ш		3 None		9 U	nk.	3 No	coverag	е		
 PCP prophylaxis 	1 0 9				Clinic				4 Oth	er Publi	c Fundir	ng	
Other neonatal anti-	1 0 9				1 HRSA-	sponsore	1 2 0	ther		ical tria	/ t prograi	m	
retroviral medication for HIV prevention	<u> </u>				3 None		9 U	nk.	9 Unk				
If yes, specify:													
This child's primary caretal	ker is:												_
1 Biologic	2 Other	3 Foster/Adoptive	4	Foster/Adoptive	7 Socia			8	Other			9 Unk.	
parent(s) VIII. PHYSICIAN's INFO	relative RMATION	parent, relative		parent, unrelated	ageno	у			(specify in	Section	VI.)		_
Infant's Physician's Nam				Telephone Number: ()			Medical Record	Number				
a 7 Hysiolair 3 Naill	(La	ast, First, M.I.)	Person	Totophone (4umber. (/			. toooiu					_
	Hospital/Facility: Compl			ng Form:			_ Telep	hone N	umber: ()_			_
- Physician identifier in IX. COMMENTS	formation is not t	ransmitted to CDC! -											
													-