I. PATIENT INFORMATION

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)
Address: _____ City: _____ County: _____ State: _____ Zip Code: _____
RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security No.: _____ ***- Patient identifier information is not transmitted to CDC! -***

INDIANA DEPARTMENT OF HEALTH PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients <13 years of age at time of diagnosis)
State Form 51202 (R / 4-25)

II. STATE HEALTH DEPARTMENT USE ONLY

Date Form completed:

_____/_____/_____

State Patient Number:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)
☐ Perinatally HIV Exposed ☐ Confirmed HIV Infection (not AIDS) ☐ AIDS ☐ Seroreverter

DATE OF LAST MEDICAL EVALUATION: _____/_____/_____

DATE OF BIRTH: _____/_____/_____ mo day yr

AGE AT DIAGNOSIS:

	Years	Months
HIV Infection (not AIDS)		
AIDS		

CURRENT STATUS: ☐ Alive ☐ Dead ☐ Unk.

DATE OF DEATH: _____/_____/_____

STATE/TERRITORY OF DEATH: _____

DATE OF INITIAL EVALUATION FOR HIV INFECTION: _____/_____/_____

Was reason for initial HIV evaluation due to clinical signs and symptoms? ☐ Yes ☐ No ☐ Unk.

SEX: ☐ Male ☐ Female

ETHNICITY (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

RACE (circle one or more): American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian/or Other Pacific Islander; White; Unknown

COUNTRY OF BIRTH: ☐ U.S. ☐ U.S. Dependencies and Possessions (incl. Puerto Rico) (specify): _____ ☐ Other (specify): _____ ☐ Unk.

Residence at diagnosis:
City:_____ County:_____ State:_____ Country:_____ Zip Code:_____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/ Country: _____

FACILITY SETTING (check one): ☐ Public ☐ Private ☐ Federal ☐ Unk.

FACILITY TYPE (check one): ☐ Physician, HMO ☐ Hospital, Inpatient ☐ Hospital, Outpatient ☐ Other (specify): _____

V. MATERNAL HISTORY

Mother's HIV infection status ***(circle one):***

Refused HIV testing; Known HIV+ during Pregnancy; Known HIV+ sometime after birth; Known HIV negative after birth; Known HIV+ sometime before birth; HIV+ with time unknown; Known HIV+ before pregnancy; Known HIV+ at time of delivery; Unknown

***Date of mother's first positive HIV confirmatory test:** _____/_____/_____

Mother was counseled about HIV testing during this pregnancy, labor or delivery? ☐ Yes ☐ No ☐ Unk.

After 1977, this child's mother had:

	Yes	No	Unk.
Injected nonprescription drugs	☐	☐	☐
HETEROSEXUAL relations with:			
- Intravenous/injection drug user	☐	☐	☐
- Bisexual male	☐	☐	☐
- Male with hemophilia/coagulation disorder	☐	☐	☐
- Transfusion recipient with documented HIV infection	☐	☐	☐
- Transplant recipient with documented HIV infection	☐	☐	☐
- Male with AIDS or documented HIV infection, risk not specified	☐	☐	☐
Received transfusion of blood/blood components (other than clotting factor)	☐	☐	☐
Received transplant of tissue/organs or artificial insemination	☐	☐	☐

Before the diagnosis of HIV Infection/AIDS, this <u>child</u> had:

	Yes	No	Unk.
Received clotting factor for hemophilia/coagulation disorder:	☐	☐	☐
(specify disorder): ☐ Factor VIII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other (specify): _____			
Received transfusion of blood/blood components (other than clotting factor):	☐	☐	☐
First: Mo. ☐☐ Yr. ☐☐ Last: Mo. ☐☐ Yr. ☐☐	Yes	No	Unk.
Received transplant of tissue/organs	☐	☐	☐
Sexual contact with a male	☐	☐	☐
Sexual contact with a female	☐	☐	☐
Injected nonprescription drugs	☐	☐	☐
Other (Alert State Health Department)	☐	☐	☐

VI. PHYSICIAN's INFORMATION

Infant's Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No: ( ) _____

VII. LABORATORY DATA

Test 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV 1/2 AG/AB ☐ EIA 1/2 ☐ Western Blot ☐ HIV-2 RNA/DNA NAAT (Qual)

☐ Qualitative Type differentiated Immunoassay
_____HIV-1 AB _____HIV-2 AB **Collection Date (mo/day/yr):** ____/____/____

Result: ☐Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate

Test 2: ☐HIV-1 RNA/DNA NAAT (Qual) ☐HIV 1/2 AG/AB ☐EIA 1/2 ☐Western Blot ☐HIV-2 RNA/DNA NAAT (Qual)

☐ Qualitative Type differentiated Immunoassay
_____HIV-1 AB _____HIV-2 AB **Collection Date (mo/day/yr):** ____/____/____

Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐Indeterminate

HIV Detection Tests (Quantitative viral load): ☐HIV-1 RNA/PCR (Quantitative viral load) ☐HIV-2 RNA/PCR (Quantitative viral load)
Result: ☐Detectable ☐Undetectable Copies/mL:_____ **Collection Date** ____/____/____

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to current diagnostic status: CD4 count_____ CD4 percentage_____% **Collection Date** ____/____/____

First CD4 RESULT <200 OR <14% CD4 count: CD4 count_____ CD4 percentage_____% **Collection Date** ____/____/____

**********PLEASE ATTACH A COPY OF ALL HIV LABS (INDLUDING ANY GENOTYPE)**********

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Def	Pres	Initial Date (mo/day/yr)	AIDS INDICATOR DISEASES	Def	Pres	Initial Date (mo/day/yr)
1)Candidiasis, bronchi, trachea or lungs		NA		14)Lymphoma, Burkitt's (or equivalent term)		NA	
2)Candidiasis, esophageal				15)Lymphoma, immunoblastic (or equivalent term)		NA	
3)Carcinoma, invasive cervical		NA		16)Lymphoma, primary in brain		NA	
4)Coccidioidomycosis, disseminated or extrapulmonary		NA		17)Mycobacterium avium complex or M.Kansasii disseminated or extrapulmonary			
5)Cryptococcosis, extrapulmonary		NA		18)*M. tuberculosis, pulmonary**			
6)Cryptosporidiosis, chronic intestinal (>1month duration)		NA		19)*M. tuberculosis,* disseminated or extrapulmonary*			
7)Cytomegalovirus disease (other than in liver, spleen, nodes)		NA		20)Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary			
8)Cytomegalovirus retinitis (with loss of vision)				21)Pneumocystis carinii pneumonia			
9)HIV encephalopathy		NA		22)Pneumonia, recurrent, in twelve (12) month period			
10)Herpes simplex: chronic ulcer(s) (>1month duration); or bronchitis, pneumonitis or esophagitis		NA		23)Progressive multifocal leukoencephalopathy		NA	
11)Histoplasmosis, disseminated or extra pulmonary		NA		24)Salmonella septicemia, recurrent		NA	
12)Isosporiasis, chronic intestinal (>1 month duration)		NA		25)Toxoplasmosis of brain			
13)Kaposi's sarcoma				26)Wasting syndrome due to HIV		NA	

Def .= definitive diagnosis Pres .= presumptive diagnosis *RVCT CASE NO:_____

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: ☐ Yes ☐ No ☐ 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: ☐Single ☐Twin ☐>2 ☐Unknown

Delivery: ☐Vaginal ☐Elective Cesarean ☐Nonelective Cesarean

☐Cesarean, unknown ☐Unknown

If Cesarean delivery, please circle all the following indications that apply:

HIV indication(high viral load) Previous Cesarean (repeat) Malpresentation(breech, transverse) Prolonged labor or failure to progress Mother's or physician's preference Fetal distress Placenta abruption or previa Other(e.g. herpes, disproportion Please Specify_____

Not Specified

NEONATAL STATUS:

☐Full Term

☐Premature

Weeks_____

☐Unknown

Birth Defects:

Yes No Unk

Rupture of membranes:

Date __ __/__ __/__ __

Time:_____

Delivery:

Date ____/____/___

Time:_____

DID MOTHER RECEIVE ANTIRETROVIRALS (ART)?

During Pregnancy? (*circle one)* Yes No Refused Unknown If yes, what week_____

During labor/delivery? *(circle one)* Yes No Refused Unknown

Prior to this pregnancy? *(circle one)* Yes No Unknown

X. INFORMATION ON MOTHER

Mother's Date of Birth

Mo. Day Yr.

_____

(Mother's Name)

Mother's State Patient No.

Birthplace of Mother:

☐ U.S. ☐ U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

☐ Other (specify): _____ ☐ Unk.

XI. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED
-Neonatal zidovudine (ZDV, AZT) for HIV prevention	☐	☐	☐	___ ___/___ ___/___ ___
-Anti-retroviral therapy for HIV treatment	☐	☐	☐	___ ___/___ ___/___ ___
-PCP prophylaxis	☐	☐	☐	___ ___/___ ___/___ ___
-Other neonatal antiretroviral medication for HIV prevention	☐	☐	☐	
If yes, specify:_____				___ ___/___ ___/___ ___

Was child breastfed?

Yes ☐ No ☐ Unk. ☐

This child has been enrolled at:

Clinical Trial

☐ NIH-sponsored ☐ Other

☐ None ☐ Unk.

Clinic

☐ HRSA-sponsored ☐ Other

☐ None ☐ Unk.

This child's medical treatment is primarily reimbursed by:

☐ Medicaid

☐ Private insurance/HMO

☐ No coverage

☐ Other Public Funding

☐ Clinical trial/ government program

☐ Unk.

This child's primary caretaker is:

☐ Biologic parent(s) ☐ Other relative ☐ Foster/Adoptive parent, relative ☐ Foster/Adoptive parent, unrelated ☐ Social service agency ☐ Other ☐ Unk.

XII. COMMENTS