New Hampshire Pediatric HIV/AIDS Case Report Form (For patients < 13 years of age)

> **Mail completed form to: NH DHHS Communicable Disease Surveillance Section,**
> **Attn: Erin Metcalf, 29 Hazen Drive, Concord, NH 03301-6504**

I. HIV/AIDS SURVEILLANCE PROGRAM USE ONLY

NH State Number	Soundex Code	Report Status	Date Received	OOS State Number
		New Update	____/_____/_____	

Document Source	New Investigation	Report Medium						Surveillance Method				
A____-_____-_____-_____	Y N U	1	2	3	4	5	6	A	F	P	R	U

II. PATIENT IDENTIFIER INFORMATION – *data not transmitted to CDC*

Patient Legal Name: _____   Phone: (   ) _____-_____
last   first   middle

Current Address:_____

City:_____ County: _____State: _____ Zip: _____

III. FORM INFORMATION

Date form completed:____/____/_____ Person completing form:_____ Phone: (   ) _____-_____
last   first

IV. CURRENT PROVIDER INFORMATION

Physician:_____ Facility Name:_____
last   first

City:_____ State:_____ Phone: (   )_____-_____ Med Rec No:_____

V. DEMOGRAPHIC INFORMATION –*complete ALL fields*

Diagnostic Status:	Sex:	Date of Birth:	Country of Birth:	Status:	Death
☐ Perinatally HIV Exposed	☐ Male	____/____/____	☐ US ☐ US Depend/Posses	☐ Alive	Date: ___/_____/_____
☐ Pediatric HIV	☐ Female		☐ Unk ☐ Other_____		**State/Terr of Death:**
☐ Pediatric AIDS			_____	☐ Dead	_____
☐ Pediatric Seroreverter					

Ethnicity:
Hispanic   ☐ Yes ☐ No

Race (check all that apply):
☐ Black/African American   ☐ White   ☐ Asian
☐ Native American or Alaskan Alaskan Native   ☐ Native Hawaiian

Residence at Perinatal Exposure: ☐ Same as Current   Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at HIV Diagnosis: ☐ Same as Current   Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at AIDS Diagnosis: ☐ Same as Current   Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at Pediatric Seroconversion: ☐ Same as Current   Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

VI. FACILITY OF DIAGNOSIS Date of Initial Evaluation for HIV: ____/____/_____ Date of Last Medical Exam: ____/____/_____

Facility of Perinatal Exposure: ☐ Same as Current _____ Physician: _____
last   first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

Facility of HIV Diagnosis: ☐ Same as Current _____ Physician: _____
last   first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

Facility of AIDS Diagnosis: ☐ Same as Current _____ Physician: _____
last   first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

VII. PATIENT HISTORY

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Mother's Demographics:

Mother's Name: _____
                   last   first   middle

Mother's Date of Birth: _____/_____/_____

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Mother's Country of Birth:
☐ US State: _____
☐ US Depend/Posses
☐ Other: _____

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HIV/AIDS SURVEILLANCE PROGRAM USE ONLY
Mother's Soundex
_____

Mother's State Number
_____

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

☐ Refused HIV testing   ☐ Known *UNinfected* after birth   ☐ Unknown
☐ Known HIV positive before pregnancy ☐ Known HIV positive at time of delivery   ☐ Known HIV positive sometime after birth
☐ Known HIV positive during pregnancy ☐ Known HIV positive sometime before birth ☐ HIV positive with time unknown

Date of mother's first positive HIV confirmatory test _____/_____/_____	Mother was counseled about HIV testing during this pregnancy, labor or delivery? ☐ Yes ☐ No ☐ Unknown

Before their first positive HIV test/AIDS diagnosis this child's mother had:	Y	N	U	Before their first positive HIV test/AIDS diagnosis this child had:	Y	N	U
Perinatally acquired HIV infection				Injected nonprescription drugs			
Injected nonprescription drugs				Received clotting factor for hemophilia/coagulation disorder			
HETEROSEXUAL contact with the following:				Received transfusion of blood/blood components (other than clotting factor)			
- Injecting drug user (IDU)				Received transplant of tissue/organs			
- Bisexual male				Sexual contact with a male			
- Male with hemophilia/coagulation disorder				Sexual contact with a female			
- Transfusion recipient with documented HIV infection				Other documented risk			
- Transplant recipient with documented HIV infection				No identified risk factor (NIR)			
- 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							

VIII. DOCUMENTED LABORATORY DATA – please record EARLIEST and MOST RECENT tests

HIV TESTS:

	Pos	Neg	Indet	Mo	Day	Yr
HIV DNA PCR						
HIV DNA PCR						
HIV DNA PCR						
HIV 1 EIA						
HIV 1 EIA						
HIV 1/HIV 2 EIA						
HIV 1/HIV 2 EIA						
HIV1 Western Blot						
HIV1 Western Blot						
HIV2 Western Blot						
HIV2 Western Blot						
Other HIV Antibody Test (Specify)_____						
Other HIV Antibody Test (Specify)_____						

VIRAL LOAD TESTS:

Test Type:	COPIES/ML:	Mo	Day	Yr
00 NASBA *03 RT-PCR (stand)* *04 RT-PCR(ultrasen)* *05 bDNA - version 2* *06 bDNA - version 3*				

IMMUNOLOGIC LAB TESTS:

	Mo	Day	Yr
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			

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

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not documented, is patient confirmed by a physician to be:

              HIV infected   Date: _____/_____/_____

              Not HIV infected Date: _____/_____/_____

IX. AIDS INDICATOR DISEASES

Disease:	Initial Dx Date Mo/Day/Yr			Presumptive	Definitive
Bacterial infection, multiple or recurrent (including salmonella septicemia)					☐
Candidiasis, bronchi, trachea, or lungs					☐
Candidiasis, esophageal				☐	☐
Coccidioidomycosis, disseminated or extrapulmonary					☐
Cryptococcosis, extrapulmonary					☐
Cryptosporidiosis, chronic intestinal (>1 mo. duration)					☐
Cytomegalovirus disease (other than liver, spleen, or nodes)					☐
Cytomegalovirus retinitis (with loss of vision)				☐	☐
HIV encephalopathy					☐
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis					☐
Histoplasmosis, disseminated or extrapulmonary					☐
Isosporiasis, chronic intestinal (>1 mo. duration)					☐

Disease:	Initial Dx Date Mo/Day/Yr			Presumptive	Definitive
Kaposi's sarcoma				☐	☐
Lymphoid interstitial pneumonia and/or pulmonary lymphoid				☐	☐
Lymphoma, Burkitt's (or equivalent term)					☐
Lymphoma, immunoblastic (or equivalent term)					☐
Lymphoma, primary in brain					☐
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary				☐	☐
M. tuberculosis, disseminated or extrapulmonary				☐	☐
Mycobacterium of other or unidentified species, disseminated or extrapulmonary				☐	☐
Pneumocystis carinii pneumonia				☐	☐
Progressive multifocal leukoencephalopathy					☐
Toxoplasmosis of brain, onset at >1 mo. of age				☐	☐
Wasting syndrome due to HIV					☐

X. BIRTH HISTORY

Birth history was available for this child: ☐ Yes ☐ No ☐ Unknown *If "No" or "Unknown", proceed to Section XI.*

Birth Hospital:

Name: _____ City: _____ State: _____ Country: _____

Residence at Birth: ☐ Same as Current   Address: _____

City: _____ County: _____ State: _____ Country: _____ Zip Code: _____

Birth Weight:
(lbs/oz and/or grams)

_____lbs. _____oz.

_____grams

Birth:
Type: ☐ Single ☐ Twin (A or B) ☐ >2 ☐ Unknown
Mode of Delivery: ☐ Vaginal ☐ Elective Caesarean ☐ Unknown
☐ Non-Elective Caesarean ☐ Caesarean, Unknown Type
Length of Membrane Rupture: _____
Birth Defects: ☐ Yes ☐ No ☐ Unknown
Specify Type(s): _____ Code: _____

Neonatal Status:
☐ Full Term (≥37wks)
☐ Premature (<36 wks)
☐ Unknown

Weeks: _____
99=Unknown, 00=None

Prenatal Care:

Month of pregnancy prenatal care began: _____
99=Unknown, 00=None

Total # of prenatal visits: _____
99=Unknown, 00=None

EDC: _____

Mother's Doctors:

OB: _____
   last   first

ID: _____
   last   first

Anti-retroviral (ART) Drug History:

- Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, starting in what week of pregnancy? _____ *99=Unknown, 00=None*

- Did mother receive ZDV or AZT during labor/delivery? ☐ Yes ☐ No ☐ Unk ☐ Refused

- Did mother receive ZDV or AZT prior to this pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused

- Did mother receive any other ART during pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, specify: _____ _____ _____ _____

- Did mother receive any other ART during labor/delivery? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, specify: _____ _____ _____ _____

XI. TREATMENT/SERVICES REFERRALS

This child has received or is receiving:

- Neonatal zidovudine (ZDV,AZT) for HIV prevention: ☐ Yes ☐ No ☐ Unknown   Date started: ___/___/____ Time started: _____

- Other neonatal ART medication for HIV prevention: ☐ Yes ☐ No ☐ Unknown   Date started: ___/___/____
  If yes, specify: _____

- ART for HIV treatment: ☐ Yes ☐ No ☐ Unknown   Date started: ___/___/____
- PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown   Date started: ___/___/____

Was child breastfed? ☐ Yes ☐ No ☐ Unknown

Is this child enrolled in a clinic/clinical trial? ☐ Yes ☐ No ☐ Unknown   If yes, name: _____

This child's primary caretaker is:

- ☐ Biological parent(s)
- ☐ Other relative
- ☐ Foster/Adoptive parent, relative
- ☐ Foster/Adoptive parent, unrelated
- ☐ Social service agency
- ☐ Other Name: _____
- ☐ Unknown

This child's medical treatment is primarily reimbursed by:

Perinatal Exposure	HIV	AIDS	
☐	☐	☐	Medicaid/Medicare #_____
☐	☐	☐	Private insurance
☐	☐	☐	No coverage
☐	☐	☐	Other public funding
☐	☐	☐	Clinic trial/program
☐	☐	☐	Unknown

This child's siblings:

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last   first   middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last   first   middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last   first   middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last   first   middle

XIII. COMMENTS

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For questions about reporting call 603-271-3932