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 STATE DEPARTMENT OF HEALTH
PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients <13 years of age at time of diagnosis)
State Form 51202 (12-02)

DATE FORM COMPLETED Mo. Day Yr.

REPORT SOURCE:

II. STATE HEALTH DEPARTMENT USE ONLY

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) 3 Perinatally HIV Exposed; 4 Confirmed HIV Infection (not AIDS); 5 AIDS; 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months — HIV Infection (not AIDS); AIDS

CURRENT STATUS: 1 Alive; 2 Dead; 3 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

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

SEX: 1 Male; 2 Female

ETHNICITY (select one): 1 Hispanic or Latino; 2 Not Hispanic or Latino; 9 Unknown

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

COUNTRY OF BIRTH: 1 U.S.; 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify): _____; 8 Other (specify): _____; 9 Unk.

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/ Country: _____ Zip Code: _____-_____

IV. FACILITY OF DIAGNOSIS

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

FACILITY SETTING (check one): 1 Public; 2 Private; 3 Federal; 9 Unk.

FACILITY TYPE (check one): 01 Physician, HMO; 31 Hospital, Inpatient; 32 Hospital, Outpatient; 88 Other (specify): _____

V. PATIENT/MATERNAL HISTORY (Respond to ALL categories)

*** Child's biologic mother's HIV infection status (check one):**
1 Refused HIV testing
2 Known to be uninfected after this child's birth
9 HIV status unknown

Biologic mother diagnosed with HIV Infection/AIDS:
3 Before this child's pregnancy
4 Known to be uninfected after this child's birth
5 At time of delivery
6 Before 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:** Mo. Yr.

*** Mother was counseled about HIV testing during this pregnancy, labor, or delivery?** Yes 1 No 0 Unk. 9

After 1977, this child's biologic mother had:	Yes	No	Unk.
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
Received transfusion of blood/blood components (other than clotting factor)	1	0	9
Received transplant of tissue/organs or artificial insemination	1	0	9

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

Received clotting factor for hemophilia/coagulation disorder: Yes 1 No 0 Unk. 9
(specify disorder): 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____

Received transfusion of blood/blood components (other than clotting factor): Yes 1 No 0 Unk. 9
First: Mo. Yr. Last: Mo. Yr.

	Yes	No	Unk.
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 Health Department)	1	0	9

I. PHYSICIAN's INFORMATION

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

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

- Physician identifier information is not transmitted to CDC! -

VII. LABORATORY DATA

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

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
HIV-1 EIA	1	0	-	9		
HIV-1 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 Mo.	TEST DATE Yr.
▪ 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 Mo.	TEST DATE Yr.
▪ 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 all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

		Mo.	Yr.
CD4 Count	cells/µL		
CD4 Count	cells/µL		
CD4 Percent	%		
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 1 No 0 Unk. 9 Specify: _____

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

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
▪ HIV-infected	1	0	9		
▪ Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
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 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
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, pulmonary*	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

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

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] 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: [1] Single [2] Twin [3] >2 [9] Unk.

DELIVERY: [1] Vaginal [2] Elective Caesarean [3] Non-elective Caesarean [4] Caesarean, unk. type [9] Unk.

BIRTH DEFECTS: 1 Yes 0 No 9 Unk.

Specify type(s): _____ Code: ____.____

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks: (99=Unk.) ____

PRENATAL CARE:

Month of pregnancy prenatal care began: Mo. ____ 99=Unk. 00=None

Total number of prenatal care visits: ____ 99=Unk. 00=None

Did mother receive zidovudine (ZDV, AZT) during pregnancy? ..... Yes [1] No [0] Refused [8] Unk. [9]

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

Did mother receive any other Anti-retroviral medication during pregnancy? ... Yes [1] No [0] Unk. [9]

If yes, specify: _____

If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? ..... Week ____ 99=Unk.

Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? ..... Yes [1] No [0] Unk. [9]

Did mother receive any other Anti-retroviral medication during labor/delivery ..... Yes [1] No [0] Unk. [9]

If yes, specify: _____

X. INFORMATION ON MOTHER / FATHER

Maternal Date of Birth

Mo. ____ Day ____ Yr. ____

_____ (Mother's Name)

_____ (Father's Name)

Maternal Soundex: ____

Maternal State Patient No. ____

Father's HIV Status (check one): [1] Positive [0] Negative [9] Unk.

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

[8] Other (specify): _____ [9] Unk.

XI. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo.	Day	Yr.
▪ Neonatal zidovudine (ZDV, AZT) for HIV prevention	1	0	9			
▪ Anti-retroviral therapy for HIV treatment	1	0	9			
▪ PCP prophylaxis	1	0	9			
▪ Other neonatal anti-retroviral medication for HIV prevention If yes, specify: _____	1	0	9			

Was child breastfed?

Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial

[1] NIH-sponsored [2] Other

[3] None [9] Unk.

Clinic

[1] HRSA-sponsored [2] Other

[3] None [9] Unk.

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] Unk.

This child's primary caretaker is:

[1] Biologic 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] Unk.

XII. COMMENTS

STATE USE ONLY

NIR STATUS: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.

NIR: Yes [1] No [0]

- ☐ Current Physician
- ☐ Send packet
- ☐ Current Address
- ☐ CLOSED Q&A
- ☐ Sent to DIS
- ☐ RETURN TO SURVEILLANCE COORDINATOR

Current Status: ☐

1 = Open (still seeking risk)
2 = Closed – Dead*
3 = Closed – Refused*
4 = Closed – Lost to follow-up*
5 = Investigated (risk still unknown)*
6 = Reclassified (risk has been found)*

*Enter month/year resolved: _____/_____

Casework done to complete report ☐

1 = 1-2 calls
2 = 2-4 calls
3 = 5-10 calls
4 = investigated – to DIS (See NIR section)
5 = other

Casework done to complete report ☐

01 = Arrived complete
02 = Demographic data
03 = Residence at Dx
04 = Hospital/Facility
05 = Risk factor
06 = Date of first Dx
07 = Laboratory data
08 = Physician info
09 = Case report

MCHD ☐	LCHD ☐	Other ☐
Surv. Coord. initials		
Follow-up date		
Follow-up plan		