DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
PEDIATRIC HIV CONFIDENTIAL CASE REPORT FORM

(Clients <13 years of age at time of diagnosis)

I. Health Department Use Only (record all dates as mm/dd/yyyy) — *Patient identifier information NOT transmitted to CDC

1. Date Rec'd at Health Department:	**2. Document Source:**	**3. State No.:** ☐New Report ☐Update
4. Did this report initiate a new case investigation? ☐Yes ☐No ☐Unknown	**5. Report Medium** ☐Field Visit ☐Mailed ☐Faxed ☐Phone ☐Electronic Transfer ☐CD/Disk	**6. Surveillance Method** ☐Active ☐Passive ☐Re-abstraction ☐Follow up ☐Unknown

II. Facility Providing Information

7. Date Form Completed:		***8. Medical Record Number:**	
***9. Person Completing Form:**		***10. Phone Number:**	
11. Facility Name:	**12. Facility ID:**	***13.Phone:**	
***14. Street Address:**			
15. City:	**16. County/*Ward:** /	**17. State/Country:** /	***18. ZIP Code:**
19. Facility Type (enter type code from reference page 5):			

III. Client Identification

***Client Name:**	**20. First Name**	**21. Middle Name**	**22. Last Name**
***Alternate Name:** (e.g., Alias, Married)	**23. First Name**	**24. Middle Name**	**25. Last Name**
***26. Phone** (type the numbers only)	**27. Address Type:** ☐Residential ☐Bad Address ☐Correctional Facility ☐Foster Home ☐Homeless ☐Postal ☐Shelter ☐Temporary		
***28. Current Street Address**			
29. City	**30. County/*Ward** /	**31. State/Country** /	***32. ZIP Code** (type the numbers only)
***33. Social Security Number**	***34. Other ID (please specify):**	***34a. Other ID Number:**	

IV. Client Demographics (record all dates as mm/dd/yyyy, type numbers only & include leading zeroes)

35. Diagnostic Status at Report: ☐Preliminary Positive ☐Perinatal HIV Exposure ☐Pediatric HIV ☐Pediatric AIDS ☐Pediatric Seroreverter		
36. Sex assigned at birth: ☐Male ☐Female ☐Unknown	**37. Date of Birth:**	**38. Alias Date of Birth:**
39. Country of Birth: ☐US ☐Other/US Dependency (please specify): ______		
40. Vital Status: ☐Alive ☐Dead	**41. Date of Death**	**42. State of Death**
43. Date of Last Medical Evaluation:	**44. Date of Initial Evaluation for HIV:**	
45. Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown	***46. Expanded Ethnicity**	
47. Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Unknown	***48. Expanded Race**	

V. Residence at Diagnosis (add additional addresses in Comments)

49. Address Type: (Check all that apply) ☐Residence at HIV Diagnosis ☐Residence at AIDS Diagnosis ☐Residence at Perinatal Exposure ☐Residence at Pediatric Seroreverter ☐Check if SAME as Current Address			
***50. Street Address:**			
51. City:	**52. County/*Ward:** /	**53. State/Country:** /	***54. ZIP Code:**

VI. Facility of Diagnosis

55.Diagnosis Type (check all that apply) ☐HIV ☐AIDS ☐Perinatal Exposure ☐Pediatric Seroreverter ☐Check if SAME as Facility Providing Information			
56. Facility Name:		***57. Phone:**	
***58. Street Address:**			
59. City:	**60. County/*Ward:**	**61. State/Country:** /	***62. ZIP Code:**
63. Facility Type (enter type code from reference page 5):			
***64. Provider Name:**	***65. Provider Phone:**	***66. Specialty:**	

Client name:

VII. Client History (respond to all questions) (record all dates as mm/dd/yyyy, type numbers only & include leading zeroes)

67. Child's biological mother's HIV Infection status (select one):
☐Refused HIV testing ☐Known to be uninfected after this child's birth ☐Known HIV+ before pregnancy ☐Known HIV+ during pregnancy ☐Known HIV+ sometime before birth ☐Known HIV+ at delivery ☐Known HIV+ after child's birth ☐HIV+, time of diagnosis unknown ☐HIV status unknown

68. Date of mother's first positive HIV confirmatory test:

69. Was the biological mother counseled about HIV testing during this pregnancy, labor or delivery? ☐Yes ☐No ☐Unknown

After 1977 and before the earliest known diagnosis of HIV infection, the client's biological mother had…

70. Perinatally acquired HIV infection ☐Yes ☐No ☐Unknown

71. Used injected non-prescription drugs ☐Yes ☐No ☐Unknown

72. Vaginal sex with male
☐Yes
☐No
☐Unknown

If Yes, answer 72a - 72f about mother's partner(s). If No or Unknown, go to 73

72a. Without using a condom ☐Yes ☐No ☐Unknown
72b. Who is an IDU ☐Yes ☐No ☐Unknown
72c. Who is HIV + ☐Yes ☐No ☐Unknown
72d. With hemophilia/coagulation disorder with documented HIV infection ☐Yes ☐No ☐Unknown
72e. With transfusion recipient with documented HIV infection ☐Yes ☐No ☐Unknown
72f. With transplant recipient with documented HIV infection ☐Yes ☐No ☐Unknown

73. Anal sex with male
☐Yes
☐No
☐Unknown

If Yes, answer 73a - 73f about mother's partner(s). If No or Unknown, go to 74

73a. Without using a condom ☐Yes ☐No ☐Unknown
73b. Who is an IDU ☐Yes ☐No ☐Unknown
73c. Who is HIV + ☐Yes ☐No ☐Unknown
73d. With hemophilia/coagulation disorder with documented HIV infection ☐Yes ☐No ☐Unknown
73e. With transfusion recipient with documented HIV infection ☐Yes ☐No ☐Unknown
73f. With transplant recipient with documented HIV infection ☐Yes ☐No ☐Unknown

74. Vaginal sex with a transgendered individual
☐Yes
☐No
☐Unknown

If Yes, answer 74a - 74f about mother's partner(s). If No or Unknown, go to 75

74a. Without using a condom ☐Yes ☐No ☐Unknown
74b. Who is an IDU ☐Yes ☐No ☐Unknown
74c. Who is HIV + ☐Yes ☐No ☐Unknown
74d. With hemophilia/coagulation disorder with documented HIV infection ☐Yes ☐No ☐Unknown
74e. With transfusion recipient with documented HIV infection ☐Yes ☐No ☐Unknown
74f. With transplant recipient with documented HIV infection ☐Yes ☐No ☐Unknown

75. Anal sex with a transgendered individual
☐Yes
☐No
☐Unknown

If Yes, answer 75a - 75f about mother's partner(s). If No or Unknown, go to 76

75a. Without using a condom ☐Yes ☐No ☐Unknown
75b. Who is an IDU ☐Yes ☐No ☐Unknown
75c. Who is HIV + ☐Yes ☐No ☐Unknown
75d. With hemophilia/coagulation disorder with documented HIV infection ☐Yes ☐No ☐Unknown
75e. With transfusion recipient with documented HIV infection ☐Yes ☐No ☐Unknown
75f. With transplant recipient with documented HIV infection ☐Yes ☐No ☐Unknown

76. Vaginal sex with an MSM ☐Yes ☐No ☐Unknown

77. Anal sex with an MSM ☐Yes ☐No ☐Unknown

78. Received transfusion of blood/blood components (other than clotting factor) ☐Yes ☐No ☐Unknown (document reason in Comments section)

78a. If yes, first date received: ___________

78b. If yes, last date received: ___________

79. Received transplant of tissue/organs or artificial insemination ☐Yes ☐No ☐Unknown

Before the diagnosis of HIV infection, this child had:

80. Injected non-prescription drugs ☐Yes ☐No ☐Unknown

81. Received clotting factor for hemophilia/coagulation disorder: ☐Yes ☐No ☐Unknown

81a. If yes, specify clotting factor: ___________

81b. If yes, date received: ___________

82. Received transfusion of blood/blood components (other than clotting factor): ☐Yes ☐No ☐Unknown

82a. If yes, first date received: ___________

82b. If yes, last date received: ___________

83. Received transplant of tissue/organs ☐Yes ☐No ☐Unknown

84. Sexual contact with male ☐Yes ☐No ☐Unknown

85. Sexual contact with female ☐Yes ☐No ☐Unknown

86. Other documented risk (please include detail in Comments section) ☐Yes ☐No ☐Unknown

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87. Is this an NIR/NRR case? ☐Yes ☐No ☐Unknown

87a. If No Risk Reported, indicate date investigation was complete: ___________

Client name:

VIII. Laboratory Data (record additional tests in Comments section)

HIV Antibody Tests at Diagnosis (non-type differentiating)

Test 1 **88. Type:** ☐HIV-1 EIA ☐HIV-1/2 EIA ☐HIV- 1/2 Ag/Ab ☐HIV-1 WB ☐HIV-1 IFA ☐HIV-2 EIA ☐HIV-2 WB ☐Other: Specify Test: ________

89. Result: ☐Positive/Reactive ☐Negative/Nonreactive ☐Indeterminate **90. Rapid Test** (check if rapid) ☐

91. Collection Date: ____________ **92. Accession #:** ____________ **93. Manufacturer:** ____________

Test 2 **94. Type:** ☐HIV-1 EIA ☐HIV-1/2 EIA ☐HIV- 1/2 Ag/Ab ☐HIV-1 WB ☐HIV-1 IFA ☐HIV-2 EIA ☐HIV-2 WB ☐Other: Specify Test: ________

95. Result: ☐Positive/Reactive ☐Negative/Nonreactive ☐Indeterminate **96. Rapid Test** (check if rapid) ☐

97. Collection Date: ____________ **98. Accession #:** ____________ **99. Manufacturer:** ____________

Test 3 **100. Type:** ☐HIV-1 EIA ☐HIV-1/2 EIA ☐HIV- 1/2 Ag/Ab ☐HIV-1 WB ☐HIV-1 IFA ☐HIV-2 EIA ☐HIV-2 WB ☐Other: Specify Test: ________

101. Result: ☐Positive/Reactive ☐Negative/Nonreactive ☐Indeterminate **102. Rapid Test** (check if rapid) ☐

103. Collection Date: ____________ **104. Accession #:** ____________ **105. Manufacturer:** ____________

HIV Antibody Tests at Diagnosis (type differentiating)

Test **106. Type:** ☐HIV-1/2 Differentiating (e.g., Multispot)

107. Result: ☐HIV-1 ☐HIV-2 ☐Both (undifferentiated) ☐Neither (negative)

108. Collection Date: ________ **109. Accession #:** ________

HIV Antibody Detection Tests

Test 1 **110. Type:** ☐HIV-1 p24 Antigen ☐HIV-1 RNA/DNA NAAT (Qual) ☐HIV-1 Culture ☐HIV-2 RNA/DNA NAAT (Qual) ☐HIV-2 Culture

111. Result: ☐Positive/Reactive ☐Negative/Nonreactive ☐Indeterminate **112. Collection date:** ____________ **113. Accession #:** ____________

Test 2 **114. Type:** ☐HIV-1 p24 Antigen ☐HIV-1 RNA/DNA NAAT (Qual) ☐HIV-1 Culture ☐HIV-2 RNA/DNA NAAT (Qual) ☐HIV-2 Culture

115. Result: ☐Positive/Reactive ☐Negative/Nonreactive ☐Indeterminate **116. Collection date:** ____________ **117. Accession #:** ____________

Immunologic Lab Tests

At or closest to current diagnosis status:	First <200 µL or <14%:
118. CD4 count ________cells/µL	**122. CD4 count** ________cells/µL
119. CD4 count ________%	**123. CD4 count** ________%
120. Collection Date: ________	**124. Collection Date:** ________
121. Accession #: ________	**125. Accession #:** ________

Viral Load Tests (include earliest detectable test after diagnosis)

Test 1 **126. Result** HIV-1 RNA VL ☐Detectable ☐Undetectable **127. Copies/ µL** ________ **128. Log** ________ **129. Collection Date:** ________ **130. Accession #:** ________

Test 2 **131. Result** HIV-1 RNA VL ☐Detectable ☐Undetectable **132. Copies/ µL** ________ **133. Log** ________ **134. Collection Date:** ________ **135. Accession #:** ________

136. Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐Yes ☐No ☐Unknown

136a. If YES, provide date (specimen collection date if known) of earliest positive test for this algorithm: ____________

If HIV laboratory tests were not documented, is the client confirmed by a physician as:

137. HIV- Not Infected ☐Yes ☐No ☐Unknown **137a. HIV-Infected** ☐Yes ☐No ☐Unknown

137b. If YES to either #137 or #137a, provide date of documentation by Physician: ________

138. Genotyping Date: **139. Phenotyping Date:**

IX. Clinical (select D for Definitive or P for Presumptive where applicable)

	D	P	Date		D	P	Date		D	P	Date
140. Bacterial infection, multiple or recurrent (including Salmonella septicemia)	☐			**148. HIV encephalopathy**	☐			**156. Lymphoma, primary in brain**	☐		
141. Candidiasis, bronchi, trachea, or lungs	☐			**149. Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis**	☐			**157. Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary**	☐	☐	
142. Candidiasis, esophageal	☐	☐		**150. Histoplasmosis, disseminated or extrapulmonary**	☐			**158. M. tuberculosis, disseminated or extrapulmonary***	☐	☐	
143. Coccidiodomycosis, disseminated or extrapulmonary	☐			**151. Isosporiasis, chronic intestinal (>1 mo. duration)**	☐			**159. Mycobacterium, of other/unidentified species, disseminated or extrapulmonary**	☐	☐	
144. Cryptococcosis, extrapulmonary	☐			**152. Kaposi's sarcoma**	☐	☐		**160. Pneumocystis pneumonia**	☐	☐	
145. Cryptosporidiosis, chronic intestinal (>1 mo. duration)	☐			**153. Lymphoid interstitial pneumonia and/or pulmonary lymphoid**	☐	☐		**161. Progressive multifocal leukoencephalopathy**	☐		
146. Cytomegalovirus disease (other than in liver, spleen, or nodes)	☐			**154. Lymphoma, Burkitt's (or equivalent)**	☐			**162. Toxoplasmosis of brain, onset at >1 mo. of age**	☐	☐	
147. Cytomegalovirus retinitis (with loss of vision)	☐	☐		**155. Lymphoma, immunoblastic (or equivalent)**	☐			**163. Wasting syndrome due to HIV**	☐		

164. Has this child been diagnosed with pulmonary tuberculosis? ☐Yes ☐No ☐Unknown	**164a. If yes,** ☐Definitive ☐Presumptive ☐Unknown	**164b. Date:**	**164c. If TB selected above, indicate RVCT Case Number:**

Client name:

X. Birth History (for Perinatal Cases Only)

165. Birth History Available? ☐Yes ☐No ☐Unknown

Residence at Birth ☐Check if SAME as current address

*166. Street Address:			
167. City:	**168. County/*Ward:**	**169. State/Country:**	***170. Zip Code:**

Hospital of Birth

171. Facility Name:			***172. Phone:**
***173. Street Address:**			
174. City:	**175. County/*Ward:**	**176. State/Country:**	***177. Zip Code:**

Birth History

178. Birth weight: lbs oz	**179. Birth Type:** ☐Single ☐Twin ☐ >2 ☐Unknown	**180. Delivery:** ☐Vaginal ☐Elective Cesarean ☐Non-Elective Cesarean ☐Cesarean, unknown type ☐Unknown
181. Birth Defects: ☐Yes ☐No ☐Unknown	**181a. If yes, please specify:**	

182. Neonatal Status: ☐Full-term ☐Premature ☐Unknown	**183. Neonatal Status Weeks:**
184. Prenatal Care- Month of pregnancy prenatal care began:	**184a. Prenatal Care- Total number of prenatal care visits:**
185. Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐Yes ☐No ☐Unknown	**185a. If yes, what week of pregnancy was zidovudine (ZDV,AZT) started?** ______
186. Did mother receive zidovudine (ZDV, AZT) during labor/delivery? ☐Yes ☐No ☐Unknown	**187. Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?** ☐Yes ☐No ☐Unknown
188. Did mother receive any other Anti-retroviral medication during pregnancy? ☐Yes ☐No ☐Unknown	**188a. If yes, please specify:**
189. Did mother receive any other Anti-retroviral medication during labor/delivery? ☐Yes ☐No ☐Unknown	**189a. If yes, please specify:**

Maternal Information

190. Maternal DOB:	**191. Maternal Soundex/Name:**	**192. Maternal State No:**	**193. Maternal Country of Birth:**
***194. Other maternal ID-List Type:**		**195. Number:**	

XI. Treatment/Services Referrals

The child received or is receiving:

196. Neonatal zidovudine (ZDV, AZT) for HIV Prevention: ☐Yes ☐No ☐Unknown **196a. If yes, date received:** __________

197. Other neonatal anti-retroviral medication for HIV Prevention: ☐Yes ☐No ☐Unknown **197a. If yes, date received:** __________

197b. If yes, please specify medication (refer to reference page 5):

198. Anti-retroviral therapy for HIV treatment: ☐Yes ☐No ☐Unknown **198a. If yes, date received:** __________

199. PCP Prophylaxis: ☐Yes ☐No ☐Unknown **199a. If yes, date received:** __________

Other Information

200. Was this child breastfed? ☐Yes ☐No ☐Unknown

201. This patient has been enrolled at: ☐ Clinical Trial (specify in comment section) ☐ Clinic (specify in comment section)

202. At time of HIV diagnosis, medical treatment primarily reimbursed by: (See reference sheet on page 6)	**203. At time of AIDS diagnosis, medical treatment primarily reimbursed by:** (See reference sheet on page 6)

204. Is the client receiving any of the following treatment reimbursements? ☐ ADAP ☐Alliance ☐Medicare

205. This child's primary caretaker is: ☐Biological parent ☐Other relative ☐Foster/Adoptive parent, relative ☐Foster/Adoptive parent, unrelated ☐Social Service Agency ☐Other (specify in comments section) ☐Unknown

Co-infections

206. Acute Hepatitis B Dx Date:	**207. Chronic Hepatitis B Dx Date:**
208. Acute Hepatitis C Dx Date:	**209. Chronic Hepatitis C Dx Date:**

***XII. Provider Comments**

210.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
Pediatric HIV CONFIDENTIAL CASE REPORT FORM

Reference Page

Question	Options
19. and 63. Facility Type	**Inpatient:** • Hospital • Other, specify **Outpatient:** • Private Physician Office • Adult HIV Clinic • Other, specify **Screening, Diagnostic, Referral Agency:** • CTS • STD Clinic • Other, specify **Other Facility:** • Emergency Room • Laboratory • Corrections • Unknown • Other, specify
197b. If Yes, list ARV Medications:	• Agenerase (amprenavir) • Aptivus (tipranavir,TPV) • Atripla (efavirenz/emtricitabine/tenofovir DF) • Combivir (lamivudine/zidovudine, 3TC/AZT) • Complera (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TDF) • Crixivan (indinavir, IDV) • Edurant (rilpivirine, RPV) • Emtriva (emtricitabine, FTC) • Epivir (lamivudine, 3TC) • Epzicom (abacavir/lamivudine, ABD/3TC) • Fortovase (saquinavir, SQV) • Fuzeon (enfuvirtide, T20) • Hepsera (adefovir) • Hivid (zalcitabine, ddC) • Hydroxyurea • Intelence (etravirine) • Invirase (saquinavir, SQV) • Isentress (raltegravir) • Kaletra (lopinavir, ritonavir) • Lexiva (fosamprenavir, 908) • Norvir (ritonavir, RTV) • Prezista (darunavir, DRV) • Rescriptor (delavirdine, DLV) • Retrovir (zidovudine, ZDV, AZT) • Reyataz (atazanavir, ATV) • Saquinavir (fortavase, invirase) • Selzentry (maraviroc) • Sustiva (efavirenz, EFV) • Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT) • Truvada (tenofovir DF/emtricitabine, TDF/FTC) • Videx (didanosine, ddl) • Videx EC (didanosine, ddl) • Viracept (nelfinavir, NFV) • Viramune (nevirapine, NVP) • Viread (tenofovir DF, TDF) • Zerit (stavudine, d4T) • Ziagen (abacavir, ABC) • Other • Unspecified
202. At time of HIV diagnosis, medical treatment primarily reimbursed by:	• CHAMPUS/TRICARE • Children's Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other
203. At time of AIDS diagnosis, medical treatment primarily reimbursed by:	• CHAMPUS/TRICARE • Children's Health Insurance Program (CHIP) • MEDICAID • MEDICARE • Private Insurance, HMO • Private Insurance, PPO • Private Insurance, Unspecified • Self Insured • State Funded, COBRA • State Funded, Other

Please print a completed copy, place into a double-sealed envelope, marked "CONFIDENTIAL," and mail or hand deliver to the address provided at the bottom of this page. You may also contact the DOH Field Investigator assigned to your site from the HIV/AIDS, Hepatitis, STD and TB Administration to retrieve the completed documents. The Field Investigator may review the documents for completeness and accuracy against the patient's medical charts. Any deficiencies will require the Field Investigator to obtain missing or discrepant information via telephone, in-person interview, chart abstraction or other methods deemed appropriate. It is not acceptable to FAX or e-mail a form with client information on it. Chapter 22 of The District of Columbia Municipal Regulations contains information on the reporting requirements for communicable diseases with a specific section for HIV. All Human Immunodeficiency Virus (HIV) infection cases (including Acquired Immune Deficiency Syndrome (AIDS)) shall be reported to the Director of the Department of Health or his or her designee. Physicians and others licensed to practice in the District under the District of Columbia Health Occupations Revision Act of 1985 (D.C. Official Code § 3-1201.01 et seq.), in charge of an AIDS diagnosis, shall report the AIDS diagnosis to the Director within forty-eight (48) hours of diagnosis and furnish information the Director deems necessary to complete a confidential case report. Additionally, physicians and others licensed under the District of Columbia Health Occupations Revision Act of 1985 shall report a HIV positive test result to the Director or his or her designee. The physician or provider, laboratory, blood bank, or other entity or facility that provides HIV testing shall report all cases of HIV infection to the Director or his or her designee.

The Government of the District of Columbia
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