New Hampshire Pediatric HIV/AIDS Case Report Form (for patients <13 years of age)
Fax completed form to: (603) 696-3017

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: ____ (last, first, middle) Phone: ( ) _____________-______________

Current Address:____

City:________________________________ County: ________________________State: _______________ Zip: ______________

III. FORM INFORMATION

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

IV. CURRENT PROVIDER INFORMATION

Physician:____ (last, first) Facility Name:______________________________________

City:_______________________________ State:______ Phone: ( )______-___________ Med Rec No:_________________

V. DEMOGRAPHIC INFORMATION –*complete ALL fields*

Diagnostic Status: ☐ Perinatally HIV Exposed ☐ Pediatric HIV ☐ Pediatric AIDS ☐ Pediatric Seroreverter

Sex: ☐ Male ☐ Female

Date of Birth: ____/____/_____

Country of Birth: ☐ US ☐ US Depend/Posses ☐ Unk ☐ Other____________ ______________________

Status: ☐ Alive ☐ Dead

Death Date: ___/_____/_____ **State/Terr of Death:** ____________________

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

Mother's Demographics:	Mother's Country of Birth:	HIV/AIDS SURVEILLANCE PROGRAM USE ONLY
Mother's Name: ______________________ (last / first / middle) Mother's Date of Birth: ____/____/_____	☐ US State: _____________ ☐ US Depend/Posses ☐ Other: __________	Mother's Soundex [ ] Mother's State Number [ ]

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

For questions about reporting call: (603) 271-4496