

# Michigan Pediatric HIV/AIDS Confidential Case Report Form

MDCH DATE ENTERED:

(Patients < 13 years of age)

## I. HEALTH DEPT USE ONLY

Document ID	Soundex Code	Report Status	Date Rec'd at MDCH	State Number
MI00-		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: \_\_\_\_\_ Patient Alias \_\_\_\_\_  
last first middle last first middle

Patient Birth Name (ex. Doe, Baby Boy): \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
last first middle

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Other 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 middle

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Med Rec No: \_\_\_\_\_ Date 1<sup>st</sup> seen: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

## V. DEMOGRAPHIC INFORMATION – please complete ALL fields

<b>Diagnostic Status:</b> <input type="checkbox"/> Perinatally HIV Exposed <input type="checkbox"/> Pediatric HIV <input type="checkbox"/> Pediatric AIDS <input type="checkbox"/> Pediatric Seroreverter	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth:</b> ____/____/____ <b>Time:</b> _____	<b>Country of Birth:</b> <input type="checkbox"/> US <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Unk <input type="checkbox"/> Other _____	<b>Status:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk	<b>Death Date:</b> ____/____/____ <b>State/Terr of Death:</b> _____
<b>Ethnicity:</b> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Arab <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<b>Race (check all that apply):</b> <input type="checkbox"/> Black/AA <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			

**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

**Facility of Perinatal Exposure:**  Same as Current \_\_\_\_\_ Physician: \_\_\_\_\_  
last first  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_  
 MRN: \_\_\_\_\_ Facility Type:  Private Physician  Hospital Inpatient  Hospital Outpatient  Clinic

**Facility of HIV Diagnosis:**  Same as Current \_\_\_\_\_ Physician: \_\_\_\_\_  
last first  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_  
 MRN: \_\_\_\_\_ Facility Type:  Private Physician  Hospital Inpatient  Hospital Outpatient  Clinic

**Facility of AIDS Diagnosis:**  Same as Current \_\_\_\_\_ Physician: \_\_\_\_\_  
last first  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_  
 MRN: \_\_\_\_\_ Facility Type:  Private Physician  Hospital Inpatient  Hospital Outpatient  Clinic

**Date of Last Medical Exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Initial Evaluation for HIV:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**VII. PATIENT/MATERNAL HISTORY – please complete ALL fields**

<b>Mother's Demographics:</b> Mother's Name: _____ <small>last first middle</small> Mother's SS#: _____ Mother's Date of Birth: ____/____/____ G ____ P ____	<b>Mother's Country of Birth:</b> <input type="checkbox"/> US State: _____ <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<b>HEALTH DEPT USE ONLY</b> 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 DNA PCR						
HIV RNA PCR						
HIV RNA PCR						
HIV RNA PCR						
HIV RNA 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) _____						
<b>GENOTYPE TESTING:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown    If YES, Date: ____/____/____ Specify Lab Performing Test: _____						

VIRAL LOAD TESTS:		Mo	Day	Yr
Test Type:	COPIES/ML:			
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 (____%)			
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)			<input type="checkbox"/>
Candidiasis, bronchi, trachea, or lungs			<input type="checkbox"/>
Candidiasis, esophageal		<input type="checkbox"/>	<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary			<input type="checkbox"/>
Cryptococcosis, extrapulmonary			<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal (>1 mo. duration)			<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)			<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)		<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy			<input type="checkbox"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis			<input type="checkbox"/>
Histoplasmosis, disseminated or extrapulmonary			<input type="checkbox"/>
Isosporiasis, chronic intestinal (>1 mo. duration)			<input type="checkbox"/>

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

**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: \_\_\_\_\_

<b>Birth Weight:</b> <i>(lbs/oz and/or grams)</i> _____ lbs. _____ oz. _____ grams	<b>Birth:</b> Type: <input type="checkbox"/> Single <input type="checkbox"/> Twin ( A or B ) <input type="checkbox"/> >2 <input type="checkbox"/> Unknown Mode of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Elective Caesarean <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Elective Caesarean <input type="checkbox"/> Caesarean, Unknown Type Length of Membrane Rupture: _____ Birth Defects: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify Type(s): _____ Code: _____	<b>Neonatal Status:</b> <input type="checkbox"/> Full Term ( ≥37wks) <input type="checkbox"/> Premature (<36 wks) <input type="checkbox"/> Unknown Weeks: _____ 99=Unknown, 00=None
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<b>Prenatal Care:</b> Month of pregnancy prenatal care began: _____ 99=Unknown, 00=None Total # of prenatal visits: _____ 99=Unknown, 00=None EDC: _____	<b>Anti-retroviral (ART) Drug History:</b> - Did mother receive zidovudine (ZDV, AZT) during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Refused If yes, starting in what week of pregnancy? _____ 99=Unknown, 00=None - Did mother receive ZDV or AZT during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Refused - Did mother receive ZDV or AZT prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Refused - Did mother receive any other ART during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Refused If yes, specify: _____ - Did mother receive any other ART during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Refused If yes, specify: _____
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**Mother's Doctors:**  
 OB: \_\_\_\_\_ last first  
 ID: \_\_\_\_\_ last first

**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: \_\_\_\_\_

<p><b>This child's primary caretaker is:</b></p> <p><input type="checkbox"/> Biological parent(s)</p> <p><input type="checkbox"/> Other relative</p> <p><input type="checkbox"/> Foster/Adoptive parent, relative</p> <p><input type="checkbox"/> Foster/Adoptive parent, unrelated</p> <p><input type="checkbox"/> Social service agency</p> <p><input type="checkbox"/> Other Name: _____</p> <p><input type="checkbox"/> Unknown</p>	<p><b>This child's medical treatment is primarily reimbursed by:</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><b>Perinatal Exposure</b></td> <td style="text-align: center;"><b>HIV</b></td> <td style="text-align: center;"><b>AIDS</b></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Medicaid/Medicare # _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Private insurance</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>No coverage</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other public funding</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Clinic trial/program</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Unknown</td> </tr> </table>	<b>Perinatal Exposure</b>	<b>HIV</b>	<b>AIDS</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid/Medicare # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Private insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other public funding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clinic trial/program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unknown
<b>Perinatal Exposure</b>	<b>HIV</b>	<b>AIDS</b>																											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid/Medicare # _____																										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Private insurance																										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No coverage																										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other public funding																										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clinic trial/program																										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unknown																										

**This child's siblings (youngest to oldest):**

last	first	middle	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: ___/___/___	Birth Hospital: _____
last	first	middle	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: ___/___/___	Birth Hospital: _____
last	first	middle	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: ___/___/___	Birth Hospital: _____
last	first	middle	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: ___/___/___	Birth Hospital: _____

**XIII. COMMENTS**

**XII. DATA MANAGEMENT – HEALTH DEPARTMENT USE ONLY**

Document ID	Source of Report	New Investigation	Report Medium	Surveillance Method
Mom's ID:M100 - _____	A____.____.____.____	Y N U	1 2 3 4 5 6	A F P R U
Lab ID:M100 - _____	A____.____.____.____	Y N U	1 2 3 4 5 6	A F P R U
B. ID:M100 - _____	A____.____.____.____	Y N U	1 2 3 4 5 6	A F P R U
M. ID:M100 - _____	A____.____.____.____	Y N U	1 2 3 4 5 6	A F P R U
Other ID:M100 - _____	A____.____.____.____	Y N U	1 2 3 4 5 6	A F P R U