

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: () _____ Medical Record No. _____
 (Last, First, M.I.) _____
 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.	Yr.
• HIV-1 EIA	1	0	-	9		
• HIV-1 EIA	1	0	-	9		
• HIV-1/HIV-2 combination EIA	1	0	-	9		
• HIV-1/HIV-2 combination 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.	Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• 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		Copies/ml					Test Date	
	Yes	No						Mo.	Yr.
	1	0							

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

	Mo.	Yr.
• CD4 Count		
• CD4 Count		
• 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 No Unk. 1 0 9

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

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

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date		AIDS INDICATOR DISEASES	Initial Diagnosis		Initial Date	
	Def.	Pres.	Mo.	Yr.		Def.	Pres.	Mo.	Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA			Kaposi's sarcoma	1	2		
Candidiasis, bronchi, trachea, or lungs	1	NA			Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Candidiasis, esophageal	1	2			Lymphoma, Burkitt's (or equivalent term)	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA			Lymphoma, immunoblastic (or equivalent term)	1	NA		
Cryptococcosis, extrapulmonary	1	NA			Lymphoma, primary in brain	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA			Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1	2		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA			M. tuberculosis, disseminated or extrapulmonary*	1	2		
Cytomegalovirus retinitis (with loss of vision)	1	2			Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
HIV encephalopathy	1	NA			Pneumocystis carinii pneumonia	1	2		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA			Progressive multifocal leukoencephalopathy	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA			Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. *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: mos.
99 = Unk.
00 = None

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

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

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

• If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks:
99 = Unk.

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

• Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unk.
 1 0 9
If yes, specify: _____

• Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unk.
 1 0 9
If yes, specify: _____

Maternal Date of Birth

Mo. Day Yr.

Maternal Sounding:

Maternal State Patient No.

Birthplace of Biologic Mother:

1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
 8 Other (specify): _____ 9 Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED
• Neonatal zidovudine (ZDV, AZT) for HIV prevention	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>
• Other neonatal anti-retroviral medication for HIV prevention	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/>

	Yes	No	Unk.	DATE STARTED
• Anti-retroviral therapy for HIV treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>
• PCP prophylaxis	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9	<input type="text"/> <input type="text"/> <input type="text"/>

If yes, specify: _____

Was child breastfed?

Yes No Unk.
 1 0 9

This child has been enrolled at:

Clinical Trial	Clinic
<input type="checkbox"/> 1 NIH-sponsored <input type="checkbox"/> 2 Other	<input type="checkbox"/> 1 HRSA-sponsored <input type="checkbox"/> 2 Other
<input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unk.	<input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unk.

This child's medical treatment is primarily reimbursed by:

<input type="checkbox"/> 1 Medicaid	<input type="checkbox"/> 4 Other Public Funding
<input type="checkbox"/> 2 Private insurance/HMO	<input type="checkbox"/> 7 Clinical trial/government program
<input type="checkbox"/> 3 No coverage	<input type="checkbox"/> 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.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). **Do not send the completed form to this address.**

