CDC PEDIATRIC HIV/AIDS CASE REPORT FORM
Instructions for Completion
January 2003

The pediatric HIV/AIDS report form * is used to report children under 13 years of age with HIV infection, AIDS, or for children that have been perinatally exposed, but are still considered HIV indeterminate. (A separate form is used for reporting HIV or AIDS in teens and adults). ** Copies of the form may be obtained by contacting one of the numbers listed on the last page.

A case report form should be completed for each child born to an HIV infected mother (i.e. perinatally HIV exposed). Case report forms should also be completed on: 1) children that meet the pediatric AIDS case definition, 2) children with confirmed HIV infection, 3) children whose infection status has not yet been determined, and 4) children who have seroreverted (lost maternal antibodies). When a child who was previously reported as HIV-infected has progressed to AIDS or has died, the form should be updated accordingly. Telephone updates are acceptable. Please call the contacts on the last page with telephone updates.

Also report all HIV infections documented by laboratory report or by physician diagnosis based on history and symptomatology. AIDS cases in children are defined by the presence of HIV infection and the presence of any of the indicator diseases listed in Section VIII of the form. Please note that there are no immunological criteria for diagnosing AIDS in children as there are with adults. NOTE: Requests for PCR analysis may be made by contacting MDCH laboratory at #517/335-9453.

SECTION I
Patient Identifier

Enter the child's full name, current address and phone number. All AIDS reports must contain these identifiers. For HIV infection reports, the name field is left blank only if the child's parents have requested anonymity in an outpatient setting and as allowed by law. Otherwise, patient name should be entered. **Please include any other information that is available such as the child's adoptive or foster family name, married or maiden name of the mother** in the comment section of the form.

SECTION II

Leave blank all of the shaded areas on the first page for "HEALTH DEPARTMENT USE ONLY"

SECTION III
Demographic Information

The following areas are required to be completed:

Diagnostic Status. 3) Perinatally Exposed 4) Confirmed HIV Infection (not AIDS)
5) AIDS 6) Seroreverter (lost maternal antibodies)

Date of birth

Age at Diagnosis and **Residence at Diagnosis** fields should reflect when the condition being reported was **first diagnosed.**

Patient's Current Vital Status

Patient's Sex

Patient's Ethnicity

Patient's Race

Note: Ethnicity and race are two different variables. The appropriate box must be checked for each variable. If applicable, more than one race may be selected.

SECTION IV

Enter the name and city of the facility/provider where the child was diagnosed with the condition being reported. Outpatient sites (hospital clinics, ER, etc.) should be marked as "other" under facility type, and specified in the space provided .

SECTION V
Pt./Maternal History

Respond to all categories in the patient/maternal history section.

Check the appropriate box corresponding with the HIV infection status of the child's biological mother's 1) Refused HIV testing (refusal must be documented in mother's chart) 2) Known to be uninfected after this child's birth 9) HIV status unknown.

Check the appropriate box regarding the timing of maternal HIV Infection/AIDS. 3)before this child's pregnancy 4)During this child's pregnancy 5) At the time of delivery 6)Before this child's birth, exact time unknown 7) After this child's birth 8) HIV-infected, unknown when diagnosed.

Enter date of mother's first positive HIV confirmatory test. Enter numerically as month and year. If a year is present without a designated month, "99" should be entered as the month followed by the documented year.

Check the appropriate box if mother was counseled about HIV testing during this pregnancy, labor or delivery. 1)Yes 0)No 9) Unknown.

Check all transmission factors (risks) that apply for both mother and child.

SECTION VI
Physician

List the physician's name (pediatrician or primary care provider) and phone number, and the name of the facility submitting the report. **Include the name and phone number of the person completing the form**. List the medical record number of the child if available.

SECTION VII
Laboratory Data

Please indicate the first HIV positive result at your facility and any other testing results. Space is provided for two separate results of each type of HIV antibody/detection test. If additional testing was done, please enter the date and results on the next page in the comments section. If laboratory documentation of a positive HIV test is unavailable in the medical record, enter the date of physician diagnosis of HIV infection or if the child is a seroreverter. **A physician diagnosis is made by clinical and/or laboratory evaluation and should be clearly documented**.

HIV Detection Tests:
Qualitative HIV viral load tests are documented as either positive or negative; indicate date test performed.

Quantitative HIV viral load test; must indicate the <u>type</u> of test as follows. When indicating a detectable viral load level, enter the test results in copies/ml and date performed.
11. NASBA-Organon
12. Reverse Transcriptase-Roche
13. Branched DNA-Chiron
18. Other viral load assay.

Enter CD4+ result information as requested. If you have several results, write the additional CD4+ counts and dates in the comments section on the next page.

SECTION VIII

For AIDS reports, check all known indicator diseases and enter dates of diagnosis. Specify whether presumptive or definitive. (Definitive diagnoses are based on specific laboratory methods, while presumptive diagnoses are those made by the clinician. A complete listing may be found in the **MMWR** supplement **No. RR-12, Vol. 43, September 30, 1994**)

Check the appropriate box if the patient had been diagnosed with pulmonary tuberculosis.

SECTION IX
Birth History

Complete this section ONLY for perinatally HIV exposed children.
Enter type of delivery. 1) vaginal 2) elective caesarean (refers to a caesarean section that occurs before rupture of membranes and before the onset of labor) 3) non-elective caesarean 4) caesarean, unknown type 5) unknown.

Enter whether the child was born with any birth defects. 1) Yes 0) No 9) Unknown. If yes, specify the type(s) and numerical code. (This information may be available on the birth hospital face sheet using ICD-9 coding).

Neonatal Status
Enter the child=s gestational age as "full term" greater than or equal to 37 weeks and "premature" is equal to or less then 36 weeks.

Enter the month prenatal care began (01 to 09) and the total number of prenatal visits. 99 = Unknown. For no prenatal care, mark "00".

Enter the week of pregnancy which zidovudine therapy was started. 99 = Unknown. If no information is available regarding the pregnancy, please supply the name of the obstetrician or the name of the mother's infectious disease doctor, if known in the comments section.

Enter whether mother received ZDV, AZT during labor/delivery. 8) refused 1) Yes 0) No 9) Unknown.

Enter whether mother received ZDV, AZT prior to this pregnancy. 1) Yes 0) No 9) Unknown

Enter whether mother received any other antiretroviral medication during pregnancy. 1) Yes 0) No 9) Unknown **If yes,** write in the name of medication received.

Enter whether mother received any other antiretroviral medication during labor/delivery. 1) Yes 0) No 9) Unknown **If yes,** write in the name of medication received.

Be sure to include the biological mother's name and date of birth in the shaded section.

SECTION X
Treatment/ Referrals

Enter whether the child is receiving or received drug therapy. Please enter month, day, and year a specific therapy was started. Enter "99" if month or day are unknown, followed by the designated year. *Note the first two questions are asking about medications for HIV prevention the third question addresses treatment for confirmed positive children.*

Answer if the child was breast-fed. 1) Yes 0) No 9) Unknown.

Please provide known information regarding clinical trial enrollment, medical treatment reimbursement, or the primary care taker.

SECTION XI
Comments

Please add any additional lab or clinical information. **Include any additional names used by mother or baby** that are different from Section 1(ie., adoptive name changes, mother's married/maiden names). Please also include names of siblings, ages, DOB's, and birth hospitals if known.

Completed forms should be mailed to the local health department (LHD) where the child resides. If this is not possible, mail forms to the LHD where the facility is located. Please address the designated local contact and mark the envelope **"Confidential"** or **"To Be Opened by addressee Only."** If you have questions on where to send completed forms, please contact Naudia Pickens or Mike Kucab.

If you have any questions regarding the use of this form, please contact your local health department, or call one of the numbers listed here.

In Southeastern Michigan, contact:
(313) 876-0353

For all other areas of Michigan, contact:
(517) 335-8165

*CDC form 50.42B Revised 01/2003
**CDC form 50.42A Revised 01/2003