

**INSTRUCTIONS FOR COMPLETION OF THE MICHIGAN PEDIATRIC  
CONFIDENTIAL HIV/AIDS CASE REPORT FORM (PCRF)  
DCH FORM #1402  
May 2020**

The Michigan Pediatric HIV/AIDS Confidential Case Report Form (PCRF) DCH Form #1402 is Michigan's version of the Centers for Disease Control (CDC) Pediatric HIV/AIDS Confidential Case Report Form #50.42B. This version now replaces all prior pediatric HIV/AIDS confidential case report forms for children under 13 that have been perinatally exposed and/or infected with HIV/AIDS. The Michigan Adult HIV/AIDS Confidential Case Report DCH Form #1355 which replaced the CDC Adult HIV/AIDS Confidential Form #50.42A is used for reporting HIV/AIDS in persons age 13 and older.

Reporting by Fax:

Pediatric HIV/AIDS Surveillance Staff at secure fax 313-456-1580

Reporting by Phone:

Pediatric HIV/AIDS Surveillance Staff at 313-456-1586

Reporting by Mail:

Michigan Department of Health and Health Services (MDHHS)

**ATTN: Pediatric Surveillance Staff**

HIV/STD Surveillance & Epidemiology Section

3044 W Grand Blvd Ste 3-300

Detroit, MI 48202

The form may be photocopied or downloaded from [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) by selecting 'HIV Case Reporting Data' and then selecting 'HIV Testing and Reporting.' More copies of the form may also be obtained by contacting the Michigan Department of Health and Human Service's Pediatric HIV/AIDS Surveillance staff. Reports may be completed by either phone or mail. When mailing completed forms to the designated office above, **please place case report forms inside of two (2) sealed envelopes to ensure that confidential information cannot be seen through the envelope. Finally, to minimize the likelihood that it will be opened inadvertently, mark the envelope "Confidential" and "To Be Opened By Addressee Only."**

Every health care provider attending a newborn infant or child born to an HIV-infected mother should report promptly every case of such perinatal exposure to HIV and any subsequent test results on every such exposed newborn infant or child until such time that either an HIV infection or a seroconversion status that is negative is confirmed. A seroreverter is a child born to an HIV-infected mother but who is antibody negative, has no laboratory evidence of viral infection, and has not had an AIDS-defining illness. In an institutional or health care facility setting, a designated agent, including, but not limited to, an infection control practitioner, may make the report for the attending health care provider. Also, an updated PCRF should also be completed when a child's HIV status or vital status has changed to any of the following: 1) Pediatric Seroreverter, 2) Pediatric HIV, 3) Pediatric AIDS, and 4) Death of the child.

Instructions for each section of the form are described below.

**NOTE:** For all instances on the case report form answers of “Y” or “Yes” will be interpreted as if the event in question has occurred. Answers of “N” or “No” will be interpreted as if the event in question did NOT occur. Answers of “Unk” or “Unknown” will be interpreted as if there was no data in the source used to complete the PCRf to allow a determination of “Yes” or “No” to be made. Finally, blank or missing answers will be interpreted as if no source was examined to allow a determination of “Yes” or “No” to be made.

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**SECTION I.  
State Health  
Department  
Use Only**

**Please leave this section blank for state health department use.**

**SECTION II.  
Patient  
Identifier  
Information**

**Enter the patient's full legal name, birth name (ex. Doe, Baby Boy), and alias name. Enter the address type, current address, phone and/or mobile number of the child's primary caretaker. Enter the social security of the child.** Also, enter the patient's full name with the last name first at the top of each subsequent page in the space provided.

**SECTION III.  
Current  
Provider  
Information**

**Please provide the full name of the physician, facility and phone number where the patient is currently receiving care.** This may or may not be the same physician or facility that provided HIV testing. If possible, provide the medical record number at this facility, the date the patient was first seen at this facility, and the date of their last (most recent) visit to the facility.

**SECTION IV.  
Facility  
Providing  
Information**

**Please provide contact information for the individual who could be reached to answer questions concerning the information provided on the PCRf.** This person can be a physician, nurse, or any confidentiality-trained staff member with knowledge to interpret and access the patient's medical information.

**SECTION V.  
Demographics**

**The following areas are required to be completed:**

**Patient's Diagnostic Status.** Check correct box.

- Perinatally HIV Exposure
- Pediatric HIV
- Pediatric AIDS
- Pediatric Seroreverter

**Patient's Sex.** Check correct box.

**Patient's Date and Time of Birth.** Please indicate with complete date (mm/dd/yyyy).

**Patient's Country of Birth.** Check correct box and include specific country if other than United States (US) or US Dependencies/Possessions.

**Patient's Vital Status.** Check correct box.

**Patient's Death Date and State/Territory of Death.** Complete, if known.

**Patient's Race.** 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.

**Patient's Ethnicity.** Ethnicity and race are two different variables. The appropriate box MUST be checked for each variable.

**Date of Last Medical Exam.**

**Date of Initial Evaluation for HIV.**

**Patient's Residence at Perinatal Exposure.** Complete, if applicable.

**Patient's Residence at HIV Diagnosis.** Complete, if applicable.

**Patient's Residence at AIDS Diagnosis.** Complete, if applicable.

**Patient's Residence at Pediatric Seroconversion.** Complete, if applicable.

**SECTION VI.  
Facility of  
Diagnosis**

**Enter the name of the facility, provider and the address, city and state of the facility where the child was diagnosed with the condition being reported.** Facility type should also be specified.

- Facility of Perinatal Exposure.
- Facility of HIV Diagnosis.
- Facility of AIDS Diagnosis.

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**SECTION  
VII.  
Patient  
/Maternal  
History**

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

**Biological Mother's Demographics.** Enter the mother's full legal name, social security number, and date of birth. Please indicate date of birth with complete date (mm/dd/yyyy). Also, include mother's gravida and parity numbers.

G = Gravida, the number of times a woman was pregnant, whether she delivered or not, including the present pregnancy.

P = Parity, the number of times a woman has come to term and delivered a baby.

**Biological Mother's Country of Birth.** Check correct box and include specific country if other than United States (US) or US Dependencies/Possessions.

**Health Dept Use Only.** Please leave this section blank for state health department use.

**Child's biological mother's HIV infection status.** Check the appropriate box corresponding with the HIV infection status of the child's biological mother at the time of the child's birth.

**Enter date of mother's first positive HIV confirmatory test.** Please indicate with complete date (mm/dd/yyyy). If a year is present without a month or day, "XX" should be entered followed by the documented year.

**Check ALL transmission factors (risks) in boxes in appropriate columns for biological mother.** Indicate dates of first and last blood transfusions, if applicable.

**Check the appropriate box if mother was counseled about HIV testing during this pregnancy.**

**Check ALL transmission factors (risks) in boxes in appropriate columns for child.**

**SECTION  
VIII.  
HIV  
Diagnostic  
Tests**

**HIV Diagnostic Tests.** Please report all positive and subsequent negative tests of the child. Indicate the test type, collection date and result.

**Physician Diagnosis.** A physician diagnosis is made by clinical and/or laboratory evaluation and should be clearly documented (e.g., in progress notes). 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.

**Viral Load Tests.** Please record both the earliest and most recent viral load tests and indicate the test type.

**CD4 Tests.** Please record both the earliest and most recent CD4 count and percent.

**Genotype Tests.** Please indicate if the child has received an HIV genotype test and if possible the date and lab at which the testing was conducted.

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**SECTION IX.  
AIDS  
Indicator  
Diseases**

**For AIDS reports, check all known indicator diseases and enter dates of diagnosis.** A complete listing and description may be found in the MMWR supplement No. RR-10, Vol. 57, December 5, 2008.

**SECTION X.  
Birth History**

**Please indicate if the birth history is available.** Check correct box. If "No" or "Unknown," proceed to section Section XI.

**Patient's Birth Hospital.** Enter the name of the facility, city, state and country of the facility. Enter "home birth," if born at home.

**Patient's Residence at Birth.** If the residence is the same as the current address in Section II, check box.

**Birth Weight.** Complete, if known.

**Birth.** Enter type of delivery, mode of delivery, and length of membrane rupture. Enter whether the child was born with any birth defects. 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 in weeks as "Full Term" and "Premature" if equal to or less than 36 weeks.

**Prenatal Care.** Enter the month of pregnancy prenatal care began (01 to 09) and the total number of visits. Enter "99" if unknown and "00" if none. Enter the Estimated Date of Confinement (EDC) or due date, this is the date when child birth is most likely to take place.

**Biological Mother's Doctors.** Please supply the name of the biological mother's obstetrician (OB) and infectious disease (ID) doctors.

**Anti-retroviral (ART) Drug History.** Enter whether mother received Zidovudine (ZDV, AZT) during pregnancy. If "Yes," enter the week of pregnancy that zidovudine therapy was started. Enter "99" if unknown and "00" if none.

Enter whether mother received Zidovudine (ZDV, AZT) during labor/delivery.

Enter whether mother received Zidovudine (ZDV, AZT) prior to pregnancy.

Enter whether mother received other ART during pregnancy. If "Yes," enter the name of ART received.

Enter whether mother received other ART during labor/delivery. If "Yes," enter the name of ART received.

**SECTION XI.  
Treatment/  
Services  
Referrals**

**Enter whether the child is receiving or received drug therapy.** Please enter a complete date (mm/dd/yyyy) that specific therapy was started. Enter "XX" if month or day are unknown, followed by the designated 4-digit year. Note: the first two questions are asking about medications for HIV prevention.

**Please indicate if the child was breastfed.** Check correct box.

**If you are aware of a clinic-based or clinical trial in which the patient participates, please indicate it by name.**

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**Please indicate who is the child's primary caretaker.** Check correct box.

**Please indicate which agency provides medical treatment reimbursement of perinatal exposure, HIV and AIDS, if applicable.**

**If you are aware of siblings of the child, please provide the full name, sex, date of birth and birth hospital of the sibling.** Also, include any sibling HIV testing and/or HIV status in the Comments Section XII.

**If you are aware of father of the child, please provide the full name and date of birth.**

**SECTION  
XII.  
Comments**

**Please add any additional laboratory, clinical, paternal or other relevant information here.**

**SECTION  
XIII.  
Data  
Management  
– State Health  
Department  
Use Only**

**Please leave this section blank for state health department use.**