Michigan Pediatric HIV/AIDS Confidential Case Report Form

(Patients < 13 years of age)

MDHHS DATE ENTERED:

I. STATE HEALTH DEPT USE ONLY

Document ID	Soundex Code	Report Status	Date Rec'd at MDHHS	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: Last:_____ First:_____ Middle:_____
Birth Name (Doe, Baby Boy): Last:_____ First:_____ Middle:_____
Patient Alias Name: Last:_____ First:_____ Middle:_____

Address Type: ☐ Residential ☐ Foster Home ☐ Shelter
Current Address:_____ City:_____ County:_____
State:_____ Zip:_____ Phone:_____ Mobile:_____ SS#:_____

III. CURRENT PROVIDER INFORMATION

Physician:_____ (last first middle) Facility Name:_____
City:_____ State:_____ Phone: ( )_____-_____

Med Rec No:_____ Date 1st seen: _____/_____/_____ Date last seen:_____/_____/_____

IV. FACILITY PROVIDING INFORMATION (☐ Same as Current Provider of Care)

Date form completed:____/____/_____ Person completing form:_____ (last first) Phone: ( )_____-_____
Facility completing form:_____ Phone: ( )_____-_____

V. DEMOGRAPHIC INFORMATION – *please complete ALL fields*

Diagnostic Status:
☐ Perinatal HIV Exposure
☐ Pediatric HIV
☐ Pediatric AIDS
☐ Pediatric Seroreverter

Sex:
☐ Male
☐ Female

Date of Birth:
____/____/_____
Time:_____

Country of Birth:
☐ US ☐ US Depend/Posses
☐ Unk ☐ Other_____

Status:
☐ Alive
☐ Dead
☐ Unk

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

Race (check all that apply):
☐ Black/AA ☐ White ☐ Asian ☐ Native American or Alaskan
☐ Hawaiian/PI ☐ Unknown ☐ Other_____

Ethnicity:
Hispanic ☐ Yes ☐ No ☐ Unk
Arab ☐ Yes ☐ No ☐ Unk

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

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

Patient Name:_____ State No:_____
last first

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

Mother's Demographics:
Mother's Name: _____
last first middle
Mother's SS#: _____
Mother's Date of Birth: ____/____/_____ G____ P____

Mother's Country of Birth:
☐ US State: _____
☐ US Depend/Posses
☐ Unknown ☐ Other: _____

HEALTH DEPT USE ONLY
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**
Perinatally acquired HIV infection			
Injected non-prescription drugs			
Received transfusion of blood/blood components (other than clotting factor)			
Received transplant of tissue/organs or artificial insemination			
HETEROSEXUAL SEX WITH:			
- An injection drug user (IDU)			
- A bisexual male			
- A male with hemophilia/coagulation disorder			
- A transfusion recipient with documented HIV infection			
- A transplant recipient with documented HIV infection			
- A male with AIDS or documented HIV infection, risk not specified			

Before their first positive HIV test/AIDS diagnosis this child had:	**Y**	**N**	**U**
Injected non-prescription drugs			
Received clotting factor for hemophilia/coagulation disorder			
Received transfusion of blood/blood components (other than clotting factor)			
Received transplant of tissue/organs			
Sexual contact with a male			
Sexual contact with a female			
Other documented risk			
No identified risk factor (NIR)			

VIII. HIV DIAGNOSTIC TESTS – please report all positive and subsequent negative tests

*You may add copies of lab results to this form and may fax form to **313-456-1580(SE MI)**

Type of Test ***At least 2 Antibody Tests must be indicated for an HIV diagnosis** IA = ImmunoAssay*	**Collection Date**	Rapid Test	Positive or Reactive	Reactive for Ag	Reactive for Ab	HIV1 Ab Positive	HIV 2 Ab Positive	Indeterminate	Undifferentiated	Negative or NonReactive	Manufacturer
HIV-1/2 Ag/Ab **Lab** IA (*Discriminating & Differentiating Screen*)		N									
HIV-1/2 Ag/Ab **Lab** IA (4th Gen)		N									
HIV1/HIV 2 Type Differentiating IA		Y									Multispot or Geenius
HIV-1 RNA/DNA Qualitative NAAT		N									
HIV-1 RNA/DNA Qualitative NAAT		N									
HIV-1 RNA/DNA Qualitative NAAT		N									

If HIV lab tests were NOT documented, is HIV diagnosis confirmed by a clinical care provider? Yes ☐ No ☐ Unk ☐
IF YES, please provide date of documentation by care provider:_____/_____/_____

HIV CARE TESTS

HIV-1 RNA Assay Quantitative Viral Load
☐ Detectable ☐ Undetectable Copies/mL _____ Collection Date_____/_____/_____
☐ Detectable ☐ Undetectable Copies/mL _____ Collection Date_____/_____/_____

CD4 Count
CD4 Count_____cells/ul CD4 Percentage_____% Collection Date_____/_____/_____
CD4 Count_____cells/ul CD4 Percentage_____% Collection Date_____/_____/_____

HIV Genotype
☐ Sanger Sequence ☐ Deep or NextGen Sequence Collection Date_____/_____/_____

Patient Name:_____ State No:_____
last first

IX. AIDS INDICATOR DISEASES

Disease:	Initial Dx Date (mm/dd/yyyy)
Bacterial infections, 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 (CMV) disease (other than liver, spleen, or nodes)	
Cytomegalovirus (CMV) retinitis (with loss of vision)	
HIV encephalopathy	
Herpes simplex virus (HSV), 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 (mm/dd/yyyy)
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 (MAC) or M. kansasii, disseminated or extrapulmonary	
M. tuberculosis, disseminated or extrapulmonary	
Mycobacterium of other or unidentified species, disseminated or extrapulmonary	
Pneumocystis carinii pneumonia (PCP)	
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.*

Hospital at Birth:

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
☐ 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 medication during pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, specify: _____ _____ _____ _____
- Did mother receive any other ART medication 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 therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____
- PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____

Was this child breastfed? ☐ Yes ☐ No ☐ Unknown

Is this child enrolled in a clinic/clinical trial? ☐ Yes ☐ No ☐ Unknown If yes, name: _____

Patient Name:_____ State No:_____
last first

This child's primary caretaker is:

- ☐ Biological parent(s)
- ☐ Other relative
- ☐ Foster/Adoptive parent, relative
- ☐ Foster/Adoptive parent, unrelated
- ☐ Social service agency
- ☐ Other (Please specify):_____
- ☐ 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

This Child's Father: _____ Date of Birth ____/____/_____
last first middle

State Health Department Use only State NO

XII. COMMENTS

XIII. DATA MANAGEMENT – STATE 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