DCH-1402, MICHIGAN PEDIATRIC HIV CONFIDENTIAL CASE REPORT
(Patients <13 years of age)

Michigan Department of Health and Human Services (MDHHS)
Fax Number: 313-456-1580
(Revised 5-24)

SECTION 1 – HEALTH DEPARTMENT USE ONLY

eHARS Entry Date

eHARS Document UID **MI00-** | Soundex | Date Received at Health Department | State Number

Document Source | Surveillance Method ☐ Active ☐ Follow-up ☐ Passive ☐ Unknown

Report Medium
☐ Field visit ☐ Mailed ☐ Faxed ☐ Phone ☐ Electronic transfer

Medicaid ID Number | MCIR ID Number | WIC ID Number

SECTION 2 – FACILITY PROVIDING INFORMATION

Date Form Completed | Medical Record Number

Person Completing Form | Phone Number

Facility Name | Phone Number

Current Address

City | County | State | Zip Code

Facility Type

Outpatient
☐ Private physician's office ☐ Pediatric clinic ☐ Pediatric HIV clinic

Inpatient
☐ Hospital

Other Facility
☐ Emergency room ☐ Laboratory
☐ Other, specify

Provider Name | Provider Phone Number

SECTION 3 – PATIENT/CHILD IDENTIFICATION

Legal Name (Last, First, Middle Name)

Birth Name (Last, First, Middle Name)

Alias Name (Last, First, Middle Name)

Patient Name (Last, First) State Number

Current Address Type (Adress Date)
☐ Residential
☐ Foster home
☐ Temporary
☐ Shelter
☐ Other

Address 1/Address 2 Phone Number

City County State/Country Zip Code

SECTION 4 – PATIENT/CHILD DEMOGRAPHIC INFORMATION

Diagnostic Status at Report
☐ Perinatal HIV Exposure ☐ Pediatric HIV
☐ Pediatric AIDS ☐ Pediatric Seroreverter

Date of Last Medical Evaluation Date of Initial Evaluation for HIV

Date of Birth Alias Date of Birth

Vital Status Date of Death State of Death
☐ 1 Alive ☐ 2 Dead

Sex Assigned at Birth
☐ Male ☐ Female

Gender Identity
☐ Boy ☐ Girl ☐ Transgender boy ☐ Transgender girl
☐ Declined to answer ☐ Unknown
☐ Additional gender identity (specify)
Date Identified

Sexual Orientation
☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual
☐ Declined to answer ☐ Unknown
☐ Additional sexual orientation (specify)
Date Identified

Ethnicity
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Other

Race (check all that apply)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

Country of Birth
☐ United States ☐ U.S. minor outlying areas
☐ Other (specify)

Patient Name (Last, First) State Number

SECTION 5 – PATIENT/CHILD RESIDENCE AT DIAGNOSIS (add additional addresses in comments)

Address Event Type

☐ Check if **SAME** as current address

☐ Residence at perinatal exposure ☐ Residence at pediatric seroreverter

☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis

Address Type

☐ Residential ☐ Foster home ☐ Temporary ☐ Shelter ☐ Other

Address 1/Address 2

City County State/Country Zip Code

SECTION 6 – PATIENT/CHILD FACILITY OF DIAGNOSIS (add additional facilities in comments)

Diagnosis Type (check all that apply to facility below)

☐ Perinatal Exposure ☐ HIV Diagnosis ☐ Stage 3 (AIDS) Diagnosis

Medical Record Number

Facility Name Phone Number

Street Address

City County State/Country Zip Code

Facility Type

Outpatient Inpatient

☐ Pediatric HIV clinic ☐ Private physician's office ☐ Pediatric clinic ☐ Hospital

Other Facility

☐ Emergency room ☐ Laboratory

Provider Name Provider Phone Number Specialty

SECTION 7 – PATIENT/CHILDBIRTH HISTORY

Birth history available

☐ Yes ☐ No ☐ Unknown

Residence at Birth

☐ Check if **SAME** as current address

Address Type

☐ Residential ☐ Foster home ☐ Temporary ☐ Shelter ☐ Other

Address 1/Address 2

City County State/Country Zip Code

Patient Name (Last, First) State Number

Facility of Birth

☐ Check if **SAME** as facility providing information

Facility Name of Birth (if child was born at home, enter “home birth”) Phone Number

Facility Type

Inpatient

☐ Hospital

Address

City County State/Country Zip Code

Birth History

Birth Weight

_____ grams __ lbs __ oz

Type

☐ Single ☐ Twin ☐ More than two

Delivery

☐ Vaginal ☐ Cesarean ☐ Unknown

If Cesarean delivery, mark all the following indications that apply.

☐ HIV indication (high viral load)
☐ Prolonged labor or failure to progress
☐ Placenta abruptia or p. previa
☐ Not specified
☐ Other (e.g., herpes, disproportion) (Specify)
☐ Previous Cesarean (repeat)
☐ Birthing person’s or physician’s preference
☐ Malpresentation (breech, transverse)
☐ Fetal distress (late decelerations)

Birth Information

	Date	**Time (use military time: noon = 12:00; midnight = 00:00)**
Rupture of membranes		
Delivery		

Congenital Disorders

☐ Yes ☐ No ☐ Unknown

If yes, specify types (Q code(s))

Neonatal Status

☐ Full-term ☐ Premature ☐ Unknown

Neonatal Gestational Age in Weeks

___ (99 = Unknown, 00 = None)

Patient Name (Last, First) State Number

Was a toxicology screen done on the patient/child after birth?
☐ Yes ☐ No ☐ Unknown

Patient/Child Results

	Date of Screen	Positive	Negative	Unknown
Alcohol		☐	☐	☐
Amphetamines		☐	☐	☐
Barbiturates		☐	☐	☐
Benzodiazepines		☐	☐	☐
Cocaine		☐	☐	☐
Crack cocaine		☐	☐	☐
Fentanyl		☐	☐	☐
Hallucinogens		☐	☐	☐
Heroin		☐	☐	☐
K2		☐	☐	☐
Marijuana (cannabis, THC, cannabinoids)		☐	☐	☐
Methadone		☐	☐	☐
Methamphetamines		☐	☐	☐
Nicotine (any tobacco)		☐	☐	☐
Opiates		☐	☐	☐
PCP		☐	☐	☐
Other (specify)		☐	☐	☐
Specific drug(s) not documented		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

SECTION 8 – PATIENT/CHILD LABORATORY DATA

Type of Test **At least 2 Antibody Tests must be indicated for an HIV diagnosis IA = ImmunoAssay**	**Collection Date**	**Rapid Test**	**Positive**	**HIV1 Ab Positive**	**HIV2 Ab Positive**	**Indeterminate**	**Negative**
HIV-1/2 Ag/Ab		☐	☐	☐	☐	☐	☐
HIV1/HIV2 IA		☐	☐	☐	☐	☐	☐
HIV-1/2 RNA/DNA NAAT (Qualitative)		☐	☐	☐	☐	☐	☐
HIV-1/2 RNA/DNA NAAT (Qualitative)		☐	☐	☐	☐	☐	☐
HIV-1/2 RNA/DNA NAAT (Qualitative)		☐	☐	☐	☐	☐	☐

Patient Name (Last, First) State Number

HIV Detection Tests

HIV-1 RNA/DNA NAAT Assay Quantitative Viral Load
☐ Detectable ☐ Undetectable

Copies/mL Collection Date

HIV-1 RNA/DNA NAAT Assay Quantitative Viral Load
☐ Detectable ☐ Undetectable

Copies/mL Collection Date

HIV-1 RNA/DNA NAAT Assay Quantitative Viral Load
☐ Detectable ☐ Undetectable

Copies/mL Collection Date

Immunologic Tests (CD4 count and percentage)

CD4 count ____ cells/µL CD4 percentage ___ % Collection Date

CD4 count ____ cells/µL CD4 percentage ___ % Collection Date

CD4 count ____ cells/µL CD4 percentage ___ % Collection Date

Drug Resistance Tests (Genotypic)

Test
☐ HIV-1 Genotype (Unspecified)

Genotype Ordering Facility Collection Date

Documentation of Tests (keep this section)

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria?
☐ Yes ☐ No ☐ Unknown

If yes, provide specimen collection date of earliest positive test result for this algorithm.

Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, quantitative NAAT (RNA or DNA), qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.

Is earliest evidence of diagnosis documented by a physician rather than by laboratory test results?

HIV-infected Date of diagnosis by physician
☐ Yes ☐ No ☐ Unknown

Not HIV-infected Date of diagnosis by physician
☐ Yes ☐ No ☐ Unknown

SECTION 9 – PATIENT/CHILD TREATMENT/SERVICES REFERRALS

Has this child ever taken any ARVs?
☐ Yes ☐ No ☐ Unknown

Child ARV Medication(s)	Reason for Use						Date Began	Date of Last Use
	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	Other (specify reason)		
1.	☐	☐	☐	☐	☐			
2.	☐	☐	☐	☐	☐			
3.	☐	☐	☐	☐	☐			

Has this child ever taken PCP prophylaxis? Date Began Date of Last Use
☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is
☐ Biological parent
☐ Foster/Adoptive parent relative
☐ Social service agency
☐ Other relative
☐ Foster/Adoptive parent, unrelated
☐ Other (specify in comments)

SECTION 10 – PATIENT/CHILD'S FATHER & SIBLINGS

Father's Name	Father's State Number			Date of Birth	Social Security Number
Child's Siblings (Last, First, Middle)	**State Number**	**Sex at Birth** M	F	**Date of Birth**	**Birth Hospital**
1.		☐	☐		
2.		☐	☐		
3.		☐	☐		
4.		☐	☐		
5.		☐	☐		

SECTION 11 – BIRTHING PERSON/MOTHER HISTORY

Birthing Person Name Birth Person Maiden Name

State Number Soundex Social Security Number Medical Record Number

Birthing Person Date of Birth Birthing Person Country of Birth

Prenatal Care—Month of Pregnancy Prenatal Care Began Gravida/Para
___ (99 = Unknown, 00 = None)

Prenatal Care—Total Number of Prenatal Care Visits
___ (99 = Unknown, 00 = None)

Patient Name (Last, First) State Number

Has the birthing person ever been pregnant before this pregnancy? Include previous pregnancies that ended in a live birth, miscarriage, stillbirth, or induced abortion.

☐ Yes ☐ No ☐ Unknown

If yes, specify how many previous pregnancies

Pregnancy outcome (select one)

	Live Birth	Miscarriage or Stillbirth	Induced abortion	Year outcome occurred (9999 = Unknown)
1.	☐	☐	☐	
2.	☐	☐	☐	
3.	☐	☐	☐	
4.	☐	☐	☐	
5.	☐	☐	☐	

(Record additional pregnancy outcomes in Comments)

Was a test result (with a specimen collection date within the 6 weeks on or before delivery) documented in the birthing person's labor/delivery record – CD4

☐ Yes ☐ No ☐ Unknown ☐ Last CD4 and Date

Was a test result (with a specimen collection date within the 6 weeks on or before delivery) documented in the birthing person's labor/delivery record – Quantitative NAAT (RNA or DNA)

☐ Yes ☐ No ☐ Unknown ☐ Last VL and Date

Did birthing person receive any (ARVs) **prior to this pregnancy**?

☐ Yes ☐ No ☐ Refused ☐ Unknown

If yes, specify all ARVs

Birthing Person ARV Medication(s)	Date Began	Date of Last Use
1.		
2.		
3.		
4.		
5.		

Did birthing person receive any ARVs **during this pregnancy?**

☐ Yes ☐ No ☐ Refused ☐ Unknown

If yes, specify all ARVs

Birthing Person ARV Medication(s)	Date Began	Date of Last Use
1.		
2.		
3.		
4.		
5.		

If no, select reason (check all that apply)

☐ No prenatal care
☐ Unknown
☐ Other (specify)
☐ Birthing person known to be HIV negative during pregnancy
☐ HIV serostatus of birthing person unknown

Did birthing person receive any ARVs **during labor/delivery?**

☐ Yes ☐ No ☐ Refused ☐ Unknown

If yes, specify all ARVs

Birthing Person ARV Medication(s)	Date Began	Date of Last Use
1.		
2.		
3.		
4.		
5.		

If no, select reason (check all that apply)

☐ Precipitous delivery/STAT Cesarean delivery
☐ Birth not in hospital
☐ Unknown
☐ HIV serostatus of birthing person unknown
☐ Birthing person tested HIV negative during pregnancy
☐ Other (specify)

Was the birthing person screened for any of the following conditions during this pregnancy? Check test(s) performed before birth.

Birthing Person	**Date of screen (mm/dd/yyyy)**	**Yes**	**No**	**Unknown**
Group B strep		☐	☐	☐
Hepatitis B (HBsAg)		☐	☐	☐
Rubella		☐	☐	☐
Syphilis (RPR)		☐	☐	☐

Were any of the following conditions diagnosed for the birthing person during this pregnancy or at the time of labor and delivery?

Birthing Person	**Date of diagnosis (mm/dd/yyyy)**	**Yes**	**No**	**Unknown**
Bacterial vaginosis		☐	☐	☐
Chlamydia trachomatis infection		☐	☐	☐
Genital herpes (HSV)		☐	☐	☐
Gonorrhea		☐	☐	☐
Group B strep		☐	☐	☐
Hepatitis B (HBsAg)		☐	☐	☐
Hepatitis C		☐	☐	☐
PID		☐	☐	☐
Syphilis (RPR)		☐	☐	☐
Trichomoniasis		☐	☐	☐

Were substances used by the birthing person during this pregnancy?
☐ Yes ☐ No ☐ Unknown

Birthing Person Result(s)	Used and injected	Used and did not inject	Used and unknown if injected	Did not use	Unknown if used
Alcohol	☐	☐	☐	☐	☐
Amphetamines	☐	☐	☐	☐	☐
Barbiturates	☐	☐	☐	☐	☐
Benzodiazepines	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐
Crack cocaine	☐	☐	☐	☐	☐
Fentanyl	☐	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐	☐
Heroin	☐	☐	☐	☐	☐
K2	☐	☐	☐	☐	☐
Marijuana (cannabis, THC, cannabinoids)	☐	☐	☐	☐	☐
Methadone	☐	☐	☐	☐	☐
Methamphetamines	☐	☐	☐	☐	☐
Nicotine (any tobacco)	☐	☐	☐	☐	☐
Opiates	☐	☐	☐	☐	☐
PCP	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐
Specific drug(s) not documented	☐	☐	☐	☐	☐

Birthing person's HIV infection status (select one)
☐ Refused HIV testing
☐ Known HIV+ before pregnancy
☐ Known HIV+ sometime before birth
☐ Known HIV+ sometime after child's birth
☐ HIV status unknown
☐ Known to be uninfected after this child's birth
☐ Known HIV+ during pregnancy
☐ Known HIV+ at time of delivery
☐ HIV+ time of diagnosis unknown

Date of birthing person's first positive test result to confirm infection.

Child breastfed/chestfed by birthing person.
☐ Yes ☐ No ☐ Unknown

Child received premasticated/pre-chewed food from birthing person.
☐ Yes ☐ No ☐ Unknown

After 1977 and before the earliest known diagnosis of HIV infection, the birthing person had

Perinatally acquired HIV infection
☐ Yes ☐ No ☐ Unknown

Injected nonprescription drugs
☐ Yes ☐ No ☐ Unknown

Birthing person had HETEROSEXUAL relations with any of the following

HETEROSEXUAL contact with person who injected drugs
☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL contact with bisexual male
☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection
☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL contact with transfusion recipient with documented HIV infection
☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL contact with transplant recipient with documented HIV infection
☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL contact with person with documented HIV infection, risk not specified
☐ Yes ☐ No ☐ Unknown

Birthing person

Received transfusion of blood/blood components
☐ Yes ☐ No ☐ Unknown

Received transplant of tissue/organs or artificial insemination
☐ Yes ☐ No ☐ Unknown

Before the diagnosis of HIV infection, this Patient/Child had

Injected nonprescription drugs
☐ Yes ☐ No ☐ Unknown

Received clotting factor for hemophilia/coagulation disorder
☐ Yes ☐ No ☐ Unknown

Received transfusion of blood/blood components
☐ Yes ☐ No ☐ Unknown

Received transplant of tissue/organs
☐ Yes ☐ No ☐ Unknown

Sexual contact with male.
☐ Yes ☐ No ☐ Unknown

Sexual contact with female
☐ Yes ☐ No ☐ Unknown

Been breastfed/chest fed by non-birthing person
☐ Yes ☐ No ☐ Unknown

Received premasticated/pre-chewed food from non-birthing person
☐ Yes ☐ No ☐ Unknown

Other documented risk (include detail in Comments)
☐ Yes ☐ No ☐ Unknown

Was a toxicology screen done on the birthing person (either during this pregnancy or at the time of delivery)?
☐ Yes ☐ No ☐ Unknown

(If screening for the same substance was done on more than one occasion, record additional dates and results in Comments).

Birthing Person Result(s)	Not screened	Unknown	Positive	Negative	Date of Screen
Alcohol	☐	☐	☐	☐	
Amphetamines	☐	☐	☐	☐	
Barbiturates	☐	☐	☐	☐	
Benzodiazepines	☐	☐	☐	☐	
Cocaine	☐	☐	☐	☐	
Crack cocaine	☐	☐	☐	☐	
Fentanyl	☐	☐	☐	☐	
Hallucinogens	☐	☐	☐	☐	
Heroin	☐	☐	☐	☐	
K2	☐	☐	☐	☐	
Marijuana (cannabis, THC, cannabinoids)	☐	☐	☐	☐	
Methadone	☐	☐	☐	☐	
Methamphetamines	☐	☐	☐	☐	
Nicotine (any tobacco)	☐	☐	☐	☐	
Opiates	☐	☐	☐	☐	
PCP	☐	☐	☐	☐	
Other (specify) _____	☐	☐	☐	☐	
Specific drug(s) not documented	☐	☐	☐	☐	

Patient Name (Last, First) State Number

Comments

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