



Illinois Department of Public Health
Pediatric HIV/AIDS Confidential Case Report
(Patients < 13 years of age at time of diagnosis)

I. Patient Information

Form with fields for Patient's name (last name, first name, middle initial), Alias, Social Security number, Current address, City, County, State, ZIP code, and Phone number.

II. Facility Completing Form

Form with fields for Date form completed (mm/dd/yyyy), Medical record number, Person completing form, Phone number, Facility completing form, Facility type, Address: City, County, State, Zip code.

III. Health Department Use Only

Form with fields for Document source (or source code), Document UID, Date received at health department (mm/dd/yyyy), Did this report initiate a new case investigation?, Reporting health department (State, City/County), State patient number, City/County patient number, Surveillance method (A, F, P, R, U), Report medium (Field visit, Mailed, Faxed, Phone, E. Transfer, Diskette).

Note: Record additional identifiers, such as Medicaid number, in the comments box (Section XI). Record the number and type of ID.

IV. Demographic Information

Form with fields for Diagnostic status at report (Perinatal HIV exposure, Pediatric HIV, Pediatric AIDS, Pediatric Seroreverter), Date of last medical evaluation (Month, Day, Year), Date of birth (Month, Day, Year), Age at HIV diagnosis (not AIDS) (Years, Months), Date of initial evaluation for HIV (Month, Day, Year), Alias date of birth (Month, Day, Year), Age at AIDS diagnosis (Years, Months).

Was reason for initial HIV evaluation due to clinical signs and symptoms: Yes No Unknown

Form with fields for Marital Status, Education, Sex Assigned at Birth, Current Gender Identity, Vital status, Date of death, State/Territory of death, Country of birth, and other demographic details.

Form with fields for Ethnicity, Extended Ethnicity, Race, and Extended Race.

Form with fields for Residence at HIV diagnosis (Same address as patient address, Address, City, County, State/Country, ZIP code).

Form with fields for Residence at AIDS diagnosis (Same address as patient address, Address, City, County, State/Country, ZIP code).

V. Facility and Provider of Diagnosis / Perinatal Exposure

<input type="checkbox"/> HIV diagnosis	<input type="checkbox"/> Perinatal exposure	Facility name			
<input type="checkbox"/> AIDS diagnosis	<input type="checkbox"/> Facility/Provider of care				
Address		City	County	State/Country	ZIP code
Facility Setting <input type="checkbox"/> Public <input type="checkbox"/> Federal (specify): _____ <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Private		Facility Type <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Laboratory <input type="checkbox"/> Counseling and testing <input type="checkbox"/> Outpatient/HIV clinic <input type="checkbox"/> Emergency room <input type="checkbox"/> Other screening, diagnostic, referral site <input type="checkbox"/> Outpatient/Other <input type="checkbox"/> STD clinic <input type="checkbox"/> Unknown <input type="checkbox"/> Correctional <input type="checkbox"/> Other (specify): _____			HRSA funding <input type="checkbox"/> None <input type="checkbox"/> Title IV <input type="checkbox"/> Title I <input type="checkbox"/> SPNS <input type="checkbox"/> Title II <input type="checkbox"/> Other <input type="checkbox"/> Title III <input type="checkbox"/> Unknown
Provider name			Provider specialty	Provider phone number	

VI. Patient / Maternal History

Child's biological mother's alias/maiden name		Child's biological mother's medical record number				
Child's biological mother's HIV infection status:						
<input type="checkbox"/> Refused HIV testing		<input type="checkbox"/> Known to be uninfected after this child's birth		<input type="checkbox"/> HIV status unknown		
<input type="checkbox"/> Known HIV+ before pregnancy		<input type="checkbox"/> Known HIV+ at time of delivery		<input type="checkbox"/> Known HIV+ after the child's birth		
<input type="checkbox"/> Known HIV+ during pregnancy		<input type="checkbox"/> Known HIV+ sometime before birth		<input type="checkbox"/> HIV+, time of diagnosis unknown		
Date of mother's first positive HIV confirmatory test	Month	Year	Was the biological mother counseled about HIV testing during this pregnancy, labor or delivery?	YES	NO	UNK.
Preceding the first positive HIV antibody test or AIDS diagnosis, the child's biological mother had (respond to all categories):				YES	NO	UNK.
• Perinatally acquired HIV infection						
• Injected non-prescription drugs						
• Heterosexual relations with any of the following:						
o Intravenous/injection drug user						
o Bisexual male						
o Male with hemophilia/coagulation disorder						
o Transfusion recipient with documented HIV infection						
o Transplant recipient with documented HIV infection						
o Male with AIDS or documented HIV infection, risk not specified						
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)						
First date received:		Last date received:				
• Received transplant of tissue/organs or artificial insemination						
Preceding the first positive HIV antibody test or AIDS diagnosis, this child had (respond to all categories):				YES	NO	UNK.
• Injected non-prescription drugs						
• Received clotting factor for hemophilia/coagulation disorder						
Specify clotting factor:		Date received (mm/dd/yyyy):				
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section)						
First date received:		Last date received:				
• Received transplant of tissue/organs						
Is transplant or artificial insemination being investigated or considered as primary mode of exposure?						
• Sexual contact with male						
Is pediatric sexual contact being investigated or considered as primary mode of exposure?						
• Sexual contact with female						
Is pediatric sexual contact being investigated or considered as primary mode of exposure?						
• Other documented risk						
Is other exposure being investigated or considered as primary mode of exposure?						
• No identified risk factor (NIR)						
Date NIR investigation was completed:						

VII. Laboratory Data

HIV Antibody Tests at Diagnosis (indicate first test—mm/dd/yyyy date)

HIV-1 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____	HIV-1/2 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____
HIV-1 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____	HIV-2 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____
Rapid	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____	HIV-2 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____
HIV-1 IFA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____				

HIV Detection Tests (record all tests—mm/dd/yyyy date)

HIV-1 P24 Antigen	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____	HIV-1 Proviral DNA (Qual)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____
HIV-1 RNA PCR (Qual)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____	HIV-2 Culture	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____
HIV-1 Culture	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	____/____/____				

Immunologic Lab Tests (record additional CD4 tests in Comments section)

At or closest to current diagnostic status	CD4 count	cells/μL	____/____/____	Collection Date (mm/dd/yyyy)	____/____/____
	CD4 percent	%	____/____/____		
First <200μL or <14%	CD4 count	cells/μL	____/____/____		
	CD4 percent	%	____/____/____		

Viral Load Tests (record only detectable viral load tests; record additional viral load tests in Comments section)

	Copies/μL	Log	Collection Date (mm/dd/yyyy)
HIV-1 RNA NASBA			____/____/____
HIV-1 RNA RT-PCR			____/____/____
HIV-1 RNA bDNA			____/____/____
HIV-1 RNA Other			____/____/____

If HIV tests were not positive or were not done, or the patient is younger than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition? Yes No Unknown

Was patient confirmed by a physician as:

HIV-infected	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If Yes , enter date of diagnosis (mm/dd/yyyy):
Not HIV-infected	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If Yes , enter date of diagnosis (mm/dd/yyyy):

VIII. Clinical Status

AIDS Indicator Diseases (Def. = definitive)	Initial Dx		Initial Date mm/dd/yyyy	AIDS Indicator Diseases (Pres. = presumptive)	Initial Dx		Initial Date mm/dd/yyyy
	Def.	Pres.			Def.	Pres.	
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		<input checked="" type="checkbox"/>		Kaposi's sarcoma			
Candidiasis, bronchi, trachea, or lungs		<input checked="" type="checkbox"/>		Lymphoid interstitial pneumonia and/or pulmonary lymphoid			
Candidiasis, esophageal				Lymphoma, Burkitt's (or equivalent)		<input checked="" type="checkbox"/>	
Coccidioidomycosis, disseminated or extrapulmonary		<input checked="" type="checkbox"/>		Lymphoma, immunoblastic (or equivalent)		<input checked="" type="checkbox"/>	
Cryptococcosis, extrapulmonary		<input checked="" type="checkbox"/>		Lymphoma, primary in brain		<input checked="" type="checkbox"/>	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		<input checked="" type="checkbox"/>		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary			
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age		<input checked="" type="checkbox"/>		M. tuberculosis, disseminated or extrapulmonary			
Cytomegalovirus retinitis (with loss of vision)				Mycobacterium, of other/unidentified species, disseminated or extrapulmonary			
HIV encephalopathy		<input checked="" type="checkbox"/>		Pneumocystis carinii pneumonia			
Herpes simplex: chronic ulcers (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 mo. of age		<input checked="" type="checkbox"/>		Progressive multifocal leukoencephalopathy		<input checked="" type="checkbox"/>	
Histoplasmosis, disseminated or extrapulmonary				Toxoplasmosis of brain, onset at >1 mo. of age			
Isosporiasis, chronic intestinal (>1 mo. duration)		<input checked="" type="checkbox"/>		Wasting syndrome due to HIV		<input checked="" type="checkbox"/>	

Has this child been diagnosed with pulmonary tuberculosis? Yes No Unknown If **Yes**, initial diagnosis and date: TB pre-1993 Presumptive Definitive Unknown (mm/dd/yyyy)

RVCT case number

IX. Birth History (for PERINATAL cases only)

Birth history available for this child: Yes No Unknown **If No or Unknown, do not complete this section.**

Residence at birth Same as residential address

Address _____ City _____ County _____ State/Country _____ ZIP code _____

Hospital at birth

Facility name _____ Phone number _____

Address _____ City _____ County _____ State/Country _____ ZIP code _____

Birthweight (enter lbs/oz OR grams) lbs _____ oz _____ _____ grams	Birth type <input type="checkbox"/> Single <input type="checkbox"/> Twin <input type="checkbox"/> >2 <input type="checkbox"/> Unknown
	Birth delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Elective caesarean <input type="checkbox"/> Non-elective caesarean <input type="checkbox"/> Caesarean, unknown type <input type="checkbox"/> Unknown
	Birth defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify types and enter codes, if known: Specify: _____ Code: _____ Specify: _____ Code: _____

Neonatal status: Full term Premature No. of weeks (gestational age): _____ (99 = Unknown)

Prenatal care—Month of pregnancy when prenatal care began: _____ (99 = Unknown) (00 = None)

Prenatal care—Total number of prenatal care visits: _____ (99 = Unknown) (00 = None)

Did mother receive zidovudine (ZDV, AZT) during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown	Did mother receive zidovudine (ZDV, AZT) during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown	Did mother receive any other antiretroviral medication during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If Yes, specify: _____
If Yes, week of pregnancy when zidovudine (ZDV, AZT) began: _____ Week (99 = Unknown)	Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Did mother receive any other antiretroviral medication during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If Yes, specify: _____

Maternal date of birth _____ Maternal Soundex _____

Maternal state patient number _____

Birthplace of biological mother

U.S. U.S. minor outlying area: _____ (specify)

Unknown Other: _____ (specify)

X. Treatment/Services Referrals

This child received or is receiving: • Neonatal zidovudine (ZDV, AZT) for HIV prevention <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Other neonatal anti-retroviral medication for HIV prevention <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify the medications: • Anti-retroviral therapy for HIV treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • PCP prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date started (mm/dd/yyyy): _____
Was this child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
This patient has been enrolled at (clinical trial) <input type="checkbox"/> NIH sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
This patient has been enrolled at (clinic) <input type="checkbox"/> HRSA sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
At time of HIV diagnosis, medical treatment primarily reimbursed by: _____	
At time of AIDS diagnosis, medical treatment primarily reimbursed by: _____	
This child's primary caretaker is: <input type="checkbox"/> Biological parent(s) <input type="checkbox"/> Foster/Adoptive parent, relative <input type="checkbox"/> Social service agency <input type="checkbox"/> Unknown <input type="checkbox"/> Other relative <input type="checkbox"/> Foster/Adoptive parent, unrelated <input type="checkbox"/> Other (if Other, please specify): _____	

XI. Comments

XII. Local Fields
