U.S. Department of Health and Human Services

Pediatric HIV Confidential Case Report Form

(Patients aged <13 years at time of perinatal exposure or patients aged <13 years at time of diagnosis)

***Information NOT transmitted to CDC**

Centers for Disease Control and Prevention (CDC)

I. Patient Identification (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 02/28/2026

***First Name** | ***Middle Name** | ***Last Name** | **Last Name Soundex**

Alternate Name Type (example: Birth, Call Me) | ***First Name** | ***Middle Name** | ***Last Name**

Address Type

◯ Residential ◯ Correctional facility ◯ Homeless ◯ Other ◯ Shelter
◯ Bad address ◯ Foster home ◯ Military ◯ Postal ◯ Temporary

***Current Address, Street** | **Address Date** (/ /)

***Phone** | **City** | **County** | **State/Country** | ***ZIP Code**

***Medical Record Number** | ***Other ID Type** | ***Number**

II. Health Department Use Only (record all dates as mm/dd/yyyy)

Date Received at Health Department (/ /) | **eHARS Document UID** | **State Number**

Reporting Health Dept—City/County | **City/County Number**

Document Source

Surveillance Method

◯ Active ◯ Passive ◯ Follow up ◯ Reabstraction ◯ Unknown

Did this report initiate a new case investigation?

◯ Yes ◯ No ◯ Unknown

Report Medium

◯ 1-Field visit ◯ 3-Faxed ◯ 5-Electronic transfer
◯ 2-Mailed ◯ 4-Phone ◯ 6-CD/disk

III. Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name | ***Phone**

***Street Address** | **City**

County | **State/Country** | ***ZIP Code**

Facility Type

Inpatient:
◯ Hospital
◯ Other, specify

Outpatient:
◯ Private physician's office
◯ Pediatric clinic
◯ Pediatric HIV clinic
◯ Other, specify

Other Facility:
◯ Emergency room
◯ Laboratory
◯ Unknown
◯ Other, specify

Date Form Completed (/ /) | ***Person Completing Form** | ***Phone**

This report to CDC is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

CS330670-B

IV. Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report ○ 3-Perinatal HIV exposure ○ 4-Pediatric HIV ○ 5-Pediatric AIDS ○ 6-Pediatric seroreverter

Sex Assigned at Birth ○ Male ○ Female ○ Unknown

Country of Birth
○ US
○ Other/US dependency (specify) _____

Date of Birth ___/___/_____

Alias Date of Birth ___/___/_____

Vital Status ○ 1-Alive ○ 2-Dead

Date of Death ___/___/_____

State of Death _____

Date of Last Medical Evaluation ___/___/_____

Date of Initial Evaluation for HIV ___/___/_____

Gender Identity
○ Boy
○ Girl
○ Transgender boy
○ Transgender girl
○ Additional gender identity (specify) _____
○ Declined to answer
○ Unknown

Date Identified ___/___/_____

Sexual Orientation
○ Straight or heterosexual
○ Lesbian or gay
○ Bisexual
○ Additional sexual orientation (specify) _____
○ Declined to answer
○ Unknown

Date Identified ___/___/_____

Ethnicity ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Unknown

Expanded Ethnicity _____

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

Expanded Race _____

V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below)
☐ Residence at HIV diagnosis
☐ Residence at stage 3 (AIDS) diagnosis
☐ Residence at perinatal exposure
☐ Residence at pediatric seroverter
☐ Check if SAME as current address

Address Type
○ Residential
○ Bad address
○ Correctional facility
○ Foster home
○ Homeless
○ Military
○ Other
○ Postal
○ Shelter
○ Temporary

***Street Address** _____

City _____

County _____

State/Country _____

***ZIP Code** _____

VI. Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below)
☐ HIV
☐ Stage 3 (AIDS)
☐ Perinatal exposure
☐ Check if SAME as facility providing information

Facility Name _____

***Phone** _____

***Street Address** _____

City _____

County _____

State/Country _____

***ZIP Code** _____

Facility Type

Inpatient:
○ Hospital
○ Other, specify _____

Outpatient:
○ Private physician's office
○ Pediatric clinic
○ Pediatric HIV clinic
○ Other, specify _____

Other Facility:
○ Emergency room
○ Laboratory
○ Unknown
○ Other, specify _____

***Provider Name** _____

***Provider Phone** _____

Specialty _____

VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Birthing person's HIV infection status (select one):

- ○ Refused HIV testing
- ○ Known to be uninfected after this child's birth
- ○ Known HIV+ before pregnancy
- ○ Known HIV+ during pregnancy
- ○ Known HIV+ sometime before birth
- ○ Known HIV+ at delivery
- ○ Known HIV+ after child's birth
- ○ HIV+, time of diagnosis unknown
- ○ HIV status 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 had:			
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	○ Yes	○ No	○ Unknown
First date received ____/____/_____ Last date received ____/____/_____			
Received transplant of tissue/organs or artificial insemination	○ Yes	○ No	○ Unknown

Before the diagnosis of HIV infection, this child had:			
Injected nonprescription drugs	○ Yes	○ No	○ Unknown
Received clotting factor for hemophilia/coagulation disorder	○ Yes	○ No	○ Unknown
Specify clotting factor: Date received ____/____/_____			
Received transfusion of blood/blood components (other than clothing factor) (document reason in Comments)	○ Yes	○ No	○ Unknown
First date received ____/____/_____ Last date received ____/____/_____			
Received transplant of tissue/organs	○ Yes	○ No	○ Unknown
Sexual contact with male	○ Yes	○ No	○ Unknown
Sexual contact with female	○ Yes	○ No	○ Unknown
Been breastfed/chestfed 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

VIII. Clinical: Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)	
Candidiasis, bronchi, trachea, or lungs	
Candidiasis, esophageal	
Carcinoma, invasive cervical	
Coccidioidomycosis, disseminated or extrapulmonary	
Cryptococcosis, extrapulmonary	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	
Cytomegalovirus retinitis (with loss of vision)	
HIV encephalopathy	
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis	
Histoplasmosis, disseminated or extrapulmonary	
Isosporiasis, chronic intestinal (>1 mo. duration)	
Kaposi's sarcoma	

Diagnosis	Dx Date
Lymphoid interstitial pneumonia and/or pulmonary lymphoid	
Lymphoma, Burkitt's (or equivalent)	
Lymphoma, immunoblastic (or equivalent)	
Lymphoma, primary in brain	
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
M. tuberculosis, pulmonary[1]	
M. tuberculosis, disseminated or extrapulmonary[1]	
Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Pneumocystis pneumonia	
Pneumonia, recurrent, in 12 mo. period	
Progressive multifocal leukoencephalopathy	
Toxoplasmosis of brain, onset at >1 mo. of age	
Wasting syndrome due to HIV	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number: _____

IX. Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays

TEST ○ HIV-1 IA ○ HIV-1/2 IA ○ HIV-1/2 Ag/Ab ○ HIV-2 IA

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
○ Positive
○ Negative
○ Indeterminate

Collection Date ___/___/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
Overall:
○ Reactive
○ Nonreactive

Analyte results:
HIV-1 Ag:
○ Reactive
○ Nonreactive

HIV-1/2 Ab:
○ Reactive
○ Nonreactive

Collection Date ___/___/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result[3]
Overall interpretation:
○ Reactive
○ Nonreactive
Index Value _____

Analyte results:
HIV-1 Ag:
○ Reactive
○ Nonreactive
○ Not reportable due to high Ab level
Index Value _____

HIV-1 Ab:
○ Reactive
○ Nonreactive
○ Reactive undifferentiated
Index Value _____

HIV-2 Ab:
○ Reactive
○ Nonreactive
○ Reactive undifferentiated
Index Value _____

Collection Date ___/___/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1/2 type differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result[4]
Overall interpretation:
○ HIV positive, untypable
○ HIV-1 positive with HIV-2 cross-reactivity
○ HIV-2 positive with HIV-1 cross-reactivity
○ HIV negative
○ HIV indeterminate
○ HIV-1 indeterminate
○ HIV-2 indeterminate
○ HIV-1 positive
○ HIV-2 positive

Analyte results:
HIV-1 Ab:
○ Positive
○ Negative
○ Indeterminate

HIV-2 Ab:
○ Positive
○ Negative
○ Indeterminate

Collection Date ___/___/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1 WB ○ HIV-1 IFA ○ HIV-2 WB

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
○ Positive
○ Negative
○ Indeterminate

Collection Date ___/___/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

HIV Detection Tests

TEST ○ HIV-1/2 RNA NAAT (Qualitative)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
○ HIV-1
○ HIV-2
○ Both (HIV-1 and HIV-2)
○ HIV, not differentiated (HIV-1 or HIV-2)
○ Neither (negative)

Collection Date ____/____/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1 RNA NAAT (Qualitative and Quantitative)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
Qualitative:
○ Reactive
○ Nonreactive

Analyte results:
HIV-1 Quantitative
○ Detectable above limit
○ Detectable within limits
○ Detectable below limit

Copies/mL _____

Log _____

Collection Date ____/____/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1 RNA/DNA NAAT (Qualitative) ○ HIV-2 RNA/DNA NAAT (Qualitative)
○ HIV-1 culture ○ HIV-2 culture

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
○ Positive
○ Negative
○ Indeterminate

Collection Date ____/____/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

TEST ○ HIV-1 RNA/DNA NAAT (Quantitative) ○ HIV-2 RNA/DNA NAAT (Quantitative)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Result
○ Detectable above limit
○ Detectable within limits
○ Detectable below limit
○ Not detected

Copies/mL _____

Log _____

Collection Date ____/____/_____

Testing Option (if applicable)
○ Point-of-care test by provider
○ Self-test, result directly observed by a provider[2]
○ Lab test, self-collected sample

Drug Resistance Tests (Genotypic)

TEST ○ HIV-1 Genotype (Unspecified)

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Collection Date
____/____/_____

Immunologic Tests (CD4 count and percentage)

CD4 count _____ **cells/µL** **CD4 percentage** _____**%** **Collection Date** ____/____/_____

Test Brand Name/Manufacturer | **Lab Name**

Facility Name | **Provider Name**

Documentation of Tests

*Complete 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.*

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 ____/____/_____

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

HIV-infected ○ Yes ○ No ○ Unknown **Date of diagnosis by physician** ____/____/_____

Not HIV-infected ○ Yes ○ No ○ Unknown **Date of diagnosis by physician** ____/____/_____

[2] Results not directly observed by a provider should be recorded in HIV Testing History. [3] Complete the overall interpretation and the analyte results. [4] Always complete the overall interpretation. Complete the analyte results when available.

X. Birth History (for patients exposed perinatally with or without consequent infection)

Birth history available? ○ Yes ○ No ○ Unknown

Residence at Birth ☐ Check if SAME as current address

Address Type ○ Residential ○ Correctional facility ○ Homeless ○ Other ○ Shelter ○ Bad address ○ Foster home ○ Military ○ Postal ○ Temporary

***Street Address** **City**

County **State/Country** ***ZIP Code**

Facility of Birth ☐ Check if SAME as facility providing information

Facility Name of Birth (If child was born at home, enter "home birth") ***Phone**

Facility Type

Inpatient:
○ Hospital
○ Other, specify

Outpatient:
○ Other, specify

Other Facility:
○ Emergency room
○ Corrections
○ Unknown
○ Other, specify

***Street Address** **City**

County **State/Country** ***ZIP Code**

Birth History

Birth Weight ____ lbs ____ oz _____ grams **Type** ○ 1-Single ○ 2-Twin ○ 3-More than two ○ 9-Unknown

Delivery ○ Vaginal ○ Cesarean ○ Unknown

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

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

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**

Neonatal Status ○ 1-Full-term ○ 2-Premature ○ 9-Unknown **Neonatal Gestational Age in Weeks** (99 = Unknown, 00 = None) ____

Was a toxicology screen done on the infant after birth? ○ Yes ○ No ○ Unknown

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

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

XI. Birthing Person History (for patients exposed perinatally with or without consequent infection)

Birthing Person Date of Birth ___/___/___ **Birthing Person Last Name Soundex** _____

Birthing Person Country of Birth _____ **Birthing Person State ID Number** _____

Birthing Person City/County ID Number ***Other Birthing Person ID (specify type of ID and ID number)**

_____ _____

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

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

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

(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 **Quantitative NAAT (RNA or DNA)** ○ Yes ○ No ○ Unknown

Did birthing person receive any antiretrovirals (ARVs) prior to this pregnancy? ○ Yes ○ No ○ Refused ○ Unknown

Date began ___/___/___ **Date of last use** ___/___/___

If YES, specify all ARVs _____

Did birthing person receive any ARVs during this pregnancy? ○ Yes ○ No ○ Refused ○ Unknown

Date began ___/___/___ **Date of last use** ___/___/___

If YES, specify all ARVs _____

If NO, select reason

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

Did birthing person receive any ARVs during labor/delivery? ○ Yes ○ No ○ Refused ○ Unknown

Date began ___/___/_____ **Date of last use** ___/___/_____

If YES, specify all ARVs _____

If NO, select reason

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

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

Condition name	Was condition screened?		
Group B strep	○ Yes, Date of screen (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Hepatitis B (HBsAg)	○ Yes, Date of screen (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Rubella	○ Yes, Date of screen (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Syphilis	○ Yes, Date of screen (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown

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

Condition name	Was condition diagnosed?		
Bacterial vaginosis	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Chlamydia trachomatis infection	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Genital herpes	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Gonorrhea	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Group B strep	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Hepatitis B (HBsAg)	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Hepatitis C	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
PID	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Syphilis	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown
Trichomoniasis	○ Yes, Date of diagnosis (mm/dd/yyyy) ___/___/_____	○ No	○ Unknown

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

Substance name	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	○	○	○	○	○

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)

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

XII. Treatment/Services Referrals (record all dates as mm/dd/yyyy)

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

ARV medication	Reason for use	Date began	Date of last use
1. _____	○ HIV Tx ○ PrEP ○ PEP ○ PMTCT ○ HBV Tx ○ Other (specify reason) _____	___/___/___	___/___/___
2. _____	○ HIV Tx ○ PrEP ○ PEP ○ PMTCT ○ HBV Tx ○ Other (specify reason) _____	___/___/___	___/___/___
3. _____	○ HIV Tx ○ PrEP ○ PEP ○ PMTCT ○ HBV Tx ○ Other (specify reason) _____	___/___/___	___/___/___
4. _____	○ HIV Tx ○ PrEP ○ PEP ○ PMTCT ○ HBV Tx ○ Other (specify reason) _____	___/___/___	___/___/___
5. _____	○ HIV Tx ○ PrEP ○ PEP ○ PMTCT ○ HBV Tx ○ Other (specify reason) _____	___/___/___	___/___/___

(Record additional ARV medications in Comments)

	Date began	Date of last use
Has this child ever taken PCP prophylaxis ○ Yes ○ No ○ Unknown	___/___/___	___/___/___

This child's primary caretaker is

○ 1-Biological parent ○ 3- Foster/Adoptive parent, relative ○ 7-Social service agency ○ 9-Unknown
○ 2-Other relative ○ 4- Foster/Adoptive parent, unrelated ○ 8-Other (specify in comments)

XIII. Comments

XIV. *Local/Optional Fields