

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

*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 ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary		*Current Address, Street				Address Date ____/____/____	
*Phone (____)		City		County		State/Country	
*Medical Record Number		*Other ID Type		*Number			

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 CDCCenters for Disease Control
and Prevention (CDC)

Form approved OMB no. 0920-0573 Exp. 03/31/2026

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 ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 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 <u>Inpatient:</u> ☐ Hospital <u>Outpatient:</u> ☐ Private physician's office ☐ Pediatric clinic <u>Other Facility:</u> ☐ Emergency room ☐ Laboratory ☐ Other, specify _____ ☐ Pediatric HIV clinic ☐ Other, specify _____ ☐ Unknown ☐ Other, specify _____					
Date Form Completed ____/____/____		*Person Completing Form		*Phone (____)	

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 ☐ Male ☐ Female ☐ Unknown/Undetermined		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 ____/____/____			
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 seroreverter		☐ Check if <u>SAME</u> 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					

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send the completed form to this address.**

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).

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 <u>SAME</u> as facility providing information			
Facility Name			*Phone ()
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type <i>Inpatient:</i> ☐ Hospital <i>Outpatient:</i> ☐ Private physician's office ☐ Pediatric clinic <i>Other Facility:</i> ☐ Emergency room ☐ Laboratory ☐ Other, specify _____ ☐ Pediatric HIV clinic ☐ Other, specify _____ ☐ Unknown ☐ Other, specify _____			
*Provider Name		*Provider Phone ()	Specialty

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

Biological Mother'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 biological mother's first positive test result to confirm infection ____/____/____	Child breastfed by biological mother ☐ Yes ☐ No ☐ Unknown (If yes) Start Date ____/____/____ Stop Date ____/____/____ Child received premasticated/pre-chewed food from biological mother ☐ Yes ☐ No ☐ Unknown
After 1977 and before the earliest known diagnosis of HIV infection, the biological mother had:	
Perinatally acquired HIV infection	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Biological mother 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
Biological mother 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 Specify clotting factor: _____ Date received ____/____/____	☐ Yes ☐ No ☐ Unknown
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	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Been breastfed by woman (not biological mother)	☐ Yes ☐ No ☐ Unknown
Received premasticated/pre-chewed food from a person (not biological mother)	☐ 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	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary ¹	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary ¹	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

¹If 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		Collection Date ____/____/____	
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive HIV-1/2 Ab: ☐ Reactive ☐ Nonreactive			
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 _____		Collection Date ____/____/____	
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 _____			
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 Collection Date ____/____/____			
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate			
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)		Lab Name _____	
Test Brand Name/Manufacturer _____		Provider Name _____	
Facility Name _____		Collection Date ____/____/____	
Result ☐ HIV-1 ☐ HIV-2 ☐ Both (HIV-1 and HIV-2) ☐ HIV, not differentiated (HIV-1 or HIV-2) ☐ Neither (negative)			
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		Collection Date ____/____/____	
Analyte results: HIV-1 Quantitative: ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit			
Copies/mL _____ Log _____			
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-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ 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/ μ L		CD4 percentage _____ %	
Collection Date ____/____/____		Collection Date ____/____/____	
Test Brand Name/Manufacturer _____		Lab Name _____	
Facility Name _____		Provider Name _____	

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

Documentation of Tests	
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 ☐ Yes ☐ No ☐ Unknown Not HIV-infected ☐ Yes ☐ No ☐ Unknown
Date of diagnosis by physician ____/____/____	Date of diagnosis by physician ____/____/____

²Results not directly observed by a provider should be recorded in HIV Testing History.³Complete the overall interpretation and the analyte results.⁴Always 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 ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ 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: ☐ 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 ☐ Biological mother'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)	Result				
	Not screened	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	☐ ____/____/____	☐	☐	☐	

XI. Biological Mother History (for patients exposed perinatally with or without consequent infection)

Biological Mother Date of Birth ____ / ____ / ____		Biological Mother Last Name Soundex			
Biological Mother Country of Birth		Biological Mother State ID Number			
Biological Mother City/County ID Number		*Other Biological Mother 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 biological mother 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		
i.	☐	☐	☐		
ii.	☐	☐	☐		
iii.	☐	☐	☐		
iv.	☐	☐	☐		
v.	☐	☐	☐		
Year outcome occurred (9999 = Unknown) ____					
(Record additional pregnancy outcomes in Comments)					
Was a test result (with specimen collection date within 6 weeks on or before delivery) documented in the biological mother's labor/delivery record? CD4 ☐ Yes ☐ No ☐ Unknown Quantitative NAAT (RNA or DNA) ☐ Yes ☐ No ☐ Unknown					
Did biological mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown					
Date began ____ / ____ / ____ Date of last use ____ / ____ / ____					
If YES, specify all ARVs					
Did biological mother 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 ☐ Biological mother known to be HIV-negative during pregnancy ☐ Unknown ☐ HIV serostatus of biological mother unknown ☐ Other (specify) _____					
Did biological mother 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 biological mother unknown ☐ Birth not in hospital ☐ Biological mother tested HIV negative during pregnancy ☐ Other (specify) _____ ☐ Unknown					
Was the biological mother screened for any of the following conditions during this pregnancy?					
Check test(s) performed before birth					
	Yes	Date of screen (mm/dd/yyyy)	No	Unknown	
Group B strep	☐	____/____/____	☐	☐	
Hepatitis B (HBsAg)	☐	____/____/____	☐	☐	
Rubella	☐	____/____/____	☐	☐	
Syphilis	☐	____/____/____	☐	☐	
Were any of the following conditions diagnosed for the biological mother during this pregnancy or at the time of labor and delivery?					
	Yes	Date of diagnosis (mm/dd/yyyy)	No	Unknown	
Bacterial vaginosis	☐	____/____/____	☐	☐	
<i>Chlamydia trachomatis</i> infection	☐	____/____/____	☐	☐	
Genital herpes	☐	____/____/____	☐	☐	
Gonorrhea	☐	____/____/____	☐	☐	
Group B strep	☐	____/____/____	☐	☐	
Hepatitis B (HBsAg)	☐	____/____/____	☐	☐	
Hepatitis C	☐	____/____/____	☐	☐	
PID	☐	____/____/____	☐	☐	
Syphilis	☐	____/____/____	☐	☐	
Trichomoniasis	☐	____/____/____	☐	☐	
Were substances used by the biological mother during this pregnancy? ☐ Yes ☐ No ☐ Unknown					
	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	☐	☐	☐	☐	☐

XI. Biological Mother History (for patients exposed perinatally with or without consequent infection) (cont)

Was a toxicology screen done on the biological mother (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)					
	Not screened	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	☐	___/___/___	☐	☐	☐

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	
	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	Other (specify reason)			
i. _____	☐	☐	☐	☐	☐	☐ _____	___/___/___	___/___/___	
ii. _____	☐	☐	☐	☐	☐	☐ _____	___/___/___	___/___/___	
iii. _____	☐	☐	☐	☐	☐	☐ _____	___/___/___	___/___/___	
iv. _____	☐	☐	☐	☐	☐	☐ _____	___/___/___	___/___/___	
v. _____	☐	☐	☐	☐	☐	☐ _____	___/___/___	___/___/___	
(Record additional ARV medications in Comments)									
Has this child ever taken PCP prophylaxis ☐ Yes ☐ No ☐ Unknown Date began ___/___/___ Date of last use ___/___/___									
This child's primary caretaker is ☐ 1-Biological parent ☐ 2-Other relative ☐ 3-Foster/Adoptive parent, relative ☐ 4-Foster/Adoptive parent, unrelated ☐ 7-Social service agency ☐ 8-Other (specify in comments) ☐ 9-Unknown									

XIII. Comments

XIV. *Local/Optional Fields
