

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 <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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 CDC

Centers for Disease Control and Prevention (CDC)

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

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

Date Received at Health Department ____/____/____	eHARS Document UID	State Number
Reporting Health Dept—City/County	City/County Number	
Document Source	Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown	
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 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 <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____ <i>Outpatient:</i> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____ <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
Date Form Completed ____/____/____	*Person Completing Form
	*Phone (____)

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

Diagnostic Status at Report <input type="checkbox"/> 3-Perinatal HIV exposure <input type="checkbox"/> 4-Pediatric HIV <input type="checkbox"/> 5-Pediatric AIDS <input type="checkbox"/> 6-Pediatric seroreverter	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown/Undetermined	Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (specify) _____
Date of Birth ____/____/____	Alias Date of Birth ____/____/____	
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead	Date of Death ____/____/____	State of Death
Date of Last Medical Evaluation ____/____/____	Date of Initial Evaluation for HIV ____/____/____	
Sexual Orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Additional sexual orientation (specify) _____ <input type="checkbox"/> Declined to answer <input type="checkbox"/> Unknown		
Date Identified ____/____/____		
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	Expanded Ethnicity	
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> 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)	<input type="checkbox"/> Residence at HIV diagnosis	<input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis	<input type="checkbox"/> Residence at perinatal exposure	<input type="checkbox"/> Residence at pediatric seroreverter	<input type="checkbox"/> Check if <u>SAME</u> as current address
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Perinatal exposure <input type="checkbox"/> Check if <u>SAME</u> as facility providing information			
Facility Name _____			*Phone () _____
*Street Address _____			
City _____	County _____	State/Country _____	*ZIP Code _____
Facility Type <u>Inpatient</u> : <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<u>Outpatient</u> : <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____	
<u>Other Facility</u> : <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> 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): <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> Known HIV+ at delivery <input type="checkbox"/> Known HIV+ after child's birth <input type="checkbox"/> HIV+, time of diagnosis unknown <input type="checkbox"/> HIV status unknown	
Date of biological mother's first positive test result to confirm infection ___/___/____	Child breastfed by biological mother <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes) Start Date ___/___/____ Stop Date ___/___/____ Child received pre-masticated/pre-chewed food from biological mother <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
After 1977 and before the earliest known diagnosis of HIV infection, the biological mother had:	
Perinatally acquired HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with person who injected drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/____ Last date received ___/___/____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Before the diagnosis of HIV infection, this child had:	
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specify clotting factor: _____ Date received ___/___/____	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/____ Last date received ___/___/____	
Received transplant of tissue/organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Been breastfed by woman (not biological mother)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received pre-masticated/pre-chewed food from a person (not biological mother)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other documented risk (include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-2 IA		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> 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: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-1/2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive		
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> 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: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index Value _____	Collection Date ____/____/____	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level Index Value _____		
HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____		
HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index Value _____		
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> 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: <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-1 positive with HIV-2 cross-reactivity <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity	Collection Date ____/____/____	
<input type="checkbox"/> HIV negative <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive		
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 WB		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
HIV Detection Tests		
TEST <input type="checkbox"/> HIV-1/2 RNA NAAT (Qualitative)		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (HIV-1 and HIV-2) <input type="checkbox"/> HIV, not differentiated (HIV-1 or HIV-2) <input type="checkbox"/> Neither (negative)	Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> HIV-1 RNA NAAT (Qualitative and Quantitative)		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result Qualitative: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	Collection Date ____/____/____	
Analyte results: HIV-1 Quantitative: <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit		
Copies/mL _____ Log _____		
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Collection Date ____/____/____	
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative)		
Test Brand Name/Manufacturer _____	Lab Name _____	
Facility Name _____	Provider Name _____	
Result <input type="checkbox"/> Detectable above limit <input type="checkbox"/> Detectable within limits <input type="checkbox"/> Detectable below limit <input type="checkbox"/> Not detected	Copies/mL _____ Log _____	
Collection Date ____/____/____		
Testing Option (if applicable) <input type="checkbox"/> Point-of-care test by provider <input type="checkbox"/> Self-test, result directly observed by a provider ² <input type="checkbox"/> Lab test, self-collected sample		
Drug Resistance Tests (Genotypic)		
TEST <input type="checkbox"/> HIV-1 Genotype (Unspecified)		
Lab Name _____	Test Brand Name/Manufacturer _____	
Provider Name _____	Facility Name _____	
	Collection Date ____/____/____	
Immunologic Tests (CD4 count and percentage)		
CD4 count _____ cells/ μ L	CD4 percentage _____ %	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 **Date of diagnosis by physician** ____/____/____
Not HIV-infected Yes No Unknown **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 _____ ***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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (cannabis, THC, cannabinoids)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (any tobacco)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific drug(s) not documented	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If YES, specify how many previous pregnancies _____ Pregnancy outcome (select one)			Year outcome occurred (9999 = Unknown)	
		Live birth	Miscarriage or Stillbirth	Induced abortion	
	i.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	ii.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	iii.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
iv.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	
v.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	
(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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Quantitative NAAT (RNA or DNA) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Did biological mother receive any antiretrovirals (ARVs) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/_____ Date of last use ___/___/_____					
If YES, specify all ARVs _____					
Did biological mother receive any ARVs during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/_____ Date of last use ___/___/_____					
If YES, specify all ARVs _____					
If NO, select reason <input type="checkbox"/> No prenatal care <input type="checkbox"/> Biological mother known to be HIV-negative during pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> HIV serostatus of biological mother unknown <input type="checkbox"/> Other (specify) _____					
Did biological mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/_____ Date of last use ___/___/_____					
If YES, specify all ARVs _____					
If NO, select reason <input type="checkbox"/> Precipitous delivery/STAT Cesarean delivery <input type="checkbox"/> HIV serostatus of biological mother unknown <input type="checkbox"/> Birth not in hospital <input type="checkbox"/> Biological mother tested HIV negative during pregnancy <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> 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	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (HBsAg)	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Chlamydia trachomatis</i> infection	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Genital herpes	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Gonorrhea	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Group B strep	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (HBsAg)	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis C	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
PID	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Trichomoniasis	<input type="checkbox"/>	___/___/_____	<input type="checkbox"/>	<input type="checkbox"/>	
Were substances used by the biological mother during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	Used and injected	Used and did not inject	Used and unknown if injected	Did not use	Unknown if used
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (cannabis, THC, cannabinoids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (any tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific drug(s) not documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana (cannabis, THC, cannabinoids)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine (any tobacco)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific drug(s) not documented	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
ii. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
iii. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
iv. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___
v. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	___/___/___	___/___/___

(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
