

Minnesota Pediatric HIV/AIDS / HIV Perinatal Exposure Confidential Case Report
 (for patients < 13 years of age at time of diagnosis/perinatal exposure)
Return completed form to Minnesota Department of Health
Attn: HIV Surveillance Unit, 625 Robert Street N., P.O. Box 64975, St. Paul, MN 55164-0975
Telephone: 651-201-5414 TTY: 651-201-5797



Date form completed (enter all dates in mm/dd/yyyy format)

I. Health Department Use Only

Soundex Code					Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reporting Health Department					State Patient Number					
						State										
Surveillance Method					City/County					Other State/City/County Number						
A	F	P	R	U	Report Medium	Field Visit	Mailed	Faxed	Phone	E. Transfer	Diskette					

Date received at MDH: _____ | Document source: _____ or source code: **A** _____ . _____ . _____

II. Patient Name (last name, first name, and middle initial), Locating Information and Identification

Patient's Name				Alias				
Home Phone No.			Cell Phone No.			Work Phone No.		
Address			City		County		State	ZIP Code
Social Security Number: _____ - _____ - _____				Other Locating: _____				

III. Demographic Information

Diagnostic Status at Report <input type="checkbox"/> Perinatal HIV Exposure <input type="checkbox"/> Pediatric HIV <input type="checkbox"/> Pediatric AIDS <input type="checkbox"/> 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

Country of Birth <input type="checkbox"/> United States <input type="checkbox"/> Other, specify _____		Language Spoken		Vital Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown		Date of Death Month Day Year			State/Territory of Death
--	--	------------------------	--	--	--	--	--	--	---------------------------------

Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Race <input type="checkbox"/> Amer. Indian/Alaska Nat. <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown		
---	--	---	--	--	--	--	--

Residence at HIV Diagnosis Same as current address

Address	City	County	State/Country	ZIP Code
---------	------	--------	---------------	----------

Residence at AIDS Diagnosis Same as current address

Address	City	County	State/Country	ZIP Code
---------	------	--------	---------------	----------

IV. Facility and Provider of Diagnosis / Perinatal Exposure / Facility of Care

<input type="checkbox"/> HIV diagnosis <input type="checkbox"/> Perinatal exposure <input type="checkbox"/> AIDS diagnosis <input type="checkbox"/> Facility/Provider of care		Facility Name		
Address	City	County	State/Country	ZIP Code

Facility Setting <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Federal if Federal , specify setting: _____					Facility Type <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Screening, Diagnostic, Referral Agency <input type="checkbox"/> Other (specify): _____				
---	--	--	--	--	---	--	--	--	--

Provider Name				Provider Phone No.
Person Completing Form			Phone No.	Medical Record No.

V. Patient / Maternal History

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	Day	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:							
○ Intravenous/injection drug user							
○ Bisexual male							
○ Male with hemophilia/coagulation disorder							
○ Transfusion recipient with documented HIV infection							
○ Transplant recipient with documented HIV infection							
○ 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 If YES - Is transplant or artificial insemination being investigated or considered as primary mode of exposure?							
• Sexual contact with male If YES - Is pediatric sexual contact being investigated or considered as primary mode of exposure?							
• Sexual contact with female If YES - Is pediatric sexual contact being investigated or considered as primary mode of exposure?							
• Other documented risk If YES - Is other exposure being investigated or considered as primary mode of exposure?							
• No identified risk factor (NIR)							
Date NIR investigation was completed: _____							

VI. Laboratory Data

HIV Antibody Tests at Diagnosis (Date of first test—mm/dd/yyyy)	Record additional HIV antibody tests	Collection Date (mm/dd/yyyy)
HIV-1 IFA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-1 IFA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV-1 Western Blot <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-1 Western Blot <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Rapid <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Rapid <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV-1 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-1 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV-1/2 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-1/2 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV-2 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-2 EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV-2 Western Blot <input type="checkbox"/> Positive <input type="checkbox"/> Negative	HIV-2 Western Blot <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
HIV Detection Tests	Collection Date (mm/dd/yyyy)	Collection Date (mm/dd/yyyy)
HIV-1 P24 Antigen <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HIV-1 P24 Antigen <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
HIV-1 RNA PCR (Qual) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HIV-1 RNA PCR (Qual) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
HIV-1 Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HIV-1 Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
HIV-1 Proviral DNA (Qual) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HIV-1 Proviral DNA (Qual) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
HIV-2 Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg	HIV-2 Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg	

Immunologic Lab Tests (record additional CD4 tests in Comments section)		Collection Date (mm/dd/yyyy)	
At or closest to current diagnostic status	CD4 count	cells/ μ L	
	CD4 percent	%	
First <200 μ L or <14%	CD4 count	cells/ μ L	
	CD4 percent	%	
Viral Load Tests (record most recent test; record additional viral load tests in Comments section)			
	Copies/ μ L	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 less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from AIDS case definition?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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):	

VII. 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)				Kaposi's sarcoma			
Candidiasis, bronchi, trachea, or lungs				Lymphoid interstitial pneumonia and/or pulmonary lymphoid			
Candidiasis, esophageal				Lymphoma, Burkitt's (or equivalent)			
Coccidioidomycosis, disseminated or extrapulmonary				Lymphoma, immunoblastic (or equivalent)			
Cryptococcosis, extrapulmonary				Lymphoma, primary in brain			
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary			
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age				<i>M. tuberculosis</i> , disseminated or extrapulmonary			
Cytomegalovirus retinitis (with loss of vision)				<i>Mycobacterium</i> , of other/unidentified species, disseminated or extrapulmonary			
HIV encephalopathy				<i>Pneumocystis carinii</i> pneumonia			
Herpes simplex: chronic ulcers (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 mo. of age				Progressive multifocal leukoencephalopathy			
Histoplasmosis, disseminated or extrapulmonary				Toxoplasmosis of brain, onset at >1 mo. of age			
Isosporiasis, chronic intestinal (>1 mo. duration)				Wasting syndrome due to HIV			
Has this child been diagnosed with pulmonary TB? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk							If Yes , initial diagnosis and date: <input type="checkbox"/> Def <input type="checkbox"/> Pres. (mm/dd/yyyy)
RVCT Case Number							

VIII. Birth History (for PERINATAL cases only)				
Birth history available for this child: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If No or Unknown , do not complete this section.				
Residence at Birth <input type="checkbox"/> Same as current residential address				
Address	City	County	State/Country	ZIP Code
Hospital at Birth				
Facility Name			Phone Number	
Address	City	County	State/Country	ZIP Code

