

**INSTRUCTIONS FOR COMPLETION OF THE  
GEORGIA PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT FORM**

The pediatric HIV/AIDS case report form should be completed for a child who is less than 13 years of age and who meets one of the following criteria:

1. Confirmed HIV infection
2. Confirmed AIDS case according to pediatric AIDS case definition
3. Born to an HIV infected mother (i.e. perinatally HIV exposed)
4. Indeterminate HIV infection status
5. Seroreverter (i.e. lost maternal antibodies)

A form should also be filled out to update information on a child who was previously reported as HIV infected and who has progressed to AIDS or has died. Please report all HIV and AIDS diagnoses and perinatal exposures, documented by laboratory report or physician diagnosis, within 7 days of diagnosis. The form should be completed by a health care provider including doctors, physician assistants, nurses, and case managers. It should NOT be completed by the patient or by a parent or guardian.

Please use the Adult HIV/AIDS Confidential Case Report form to report individuals 13 or older. It can be downloaded from <http://health.state.ga.us/epi/hivaids>.

These instructions and the enclosed form may be downloaded and photocopied from <http://health.state.ga.us/epi/hivaids>. Additional copies of these forms may be obtained by calling 1-800-827-9769. Please mail completed reports in a double envelope marked “Confidential” and “To be Opened by Addressee Only” to:

**Georgia Division of Public Health**  
**Epi Section**  
**P.O. Box 2107**  
**Atlanta, GA 30301**  
 Phone: 1-800-827-9769  
<http://health.state.ga.us/epi/hivaids>

<b>SECTION I PATIENT IDENTIFIER</b> <i>(Not submitted to CDC and is for state/local use only)</i>	<ul style="list-style-type: none"> <li>• Please record the patient’s full name, most current address and phone number</li> <li>• Please make sure to enter the date the form is complete.</li> <li>• <b>Note:</b> It is important that all information in this section be completed. If available, include information pertaining to foster/adoptive parents’ name and/or a mother’s married or maiden name in the Comments section (Section XI)</li> </ul>
<b>SECTION II HEALTH DEPARTMENT USE ONLY</b>	<ul style="list-style-type: none"> <li>• <b>PLEASE LEAVE THIS SECTION BLANK</b></li> </ul>
<b>SECTION III DEMOGRAPHIC INFORMATION</b>	<b>Diagnostic Status</b> <ul style="list-style-type: none"> <li>• Please check only one box</li> <li>• <b>Note:</b> Seroreverter refers to the loss of maternal antibodies</li> </ul>

	<p><b>Date of Last Medical Evaluation</b></p> <ul style="list-style-type: none"> <li>• Enter the date of last medical evaluation up in month/year format</li> </ul> <p><b>Date of Birth</b></p> <ul style="list-style-type: none"> <li>• Please document date of birth in mo/day/yr format (e.g. 01/31/80)</li> </ul> <p><b>Age at HIV/AIDS Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Please record age of first diagnosis in years and months format</li> <li>• Leave this section blank if not reporting a confirmed HIV or AIDS case</li> </ul> <p><b>Current Status</b></p> <ul style="list-style-type: none"> <li>• Indicate if patient is alive or deceased at time of report</li> </ul> <p><b>Death Information</b></p> <ul style="list-style-type: none"> <li>• If patient is deceased, please record date of death and location</li> </ul> <p><b>Initial HIV Evaluation</b></p> <ul style="list-style-type: none"> <li>• Please record the date of initial evaluation for HIV infection in month/year format</li> <li>• Indicate whether the patient was evaluated for HIV/AIDS based on clinical signs and symptoms</li> </ul> <p><b>Sex</b></p> <ul style="list-style-type: none"> <li>• Please check appropriate box for sex at birth</li> </ul> <p><b>Ethnicity</b></p> <ul style="list-style-type: none"> <li>• If ethnicity is unknown, check “unknown”</li> <li>• <b>Note:</b> Ethnicity and race are two different, self-reported variables. The appropriate box must be checked for each variable. If patient is of Hispanic ethnicity, a race category should still be checked if known</li> </ul> <p><b>Race</b></p> <ul style="list-style-type: none"> <li>• More than one race can be checked</li> </ul> <p><b>Country of Birth</b></p> <ul style="list-style-type: none"> <li>• For U.S. Dependencies and Territories and other countries of birth, please specify</li> </ul> <p><b>Residence at Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Enter the patient’s residence at the time of the diagnostic status being reported</li> <li>• If patient’s “residence at diagnosis” cannot be located in the chart, please write “unknown”</li> </ul>
<p><b>SECTION IV FACILITY OF DIAGNOSIS</b></p>	<ul style="list-style-type: none"> <li>• Please enter the name, city, and state/country of the facility where the diagnostic status being reported was made</li> <li>• Check the appropriate boxes for the facility setting and type</li> <li>• <b>Note:</b> Outpatient sites such as hospital clinics or emergency rooms should be marked as “other” and specified in the space provided</li> </ul>

<p><b>SECTION V PATIENT/ MATERNAL HISTORY</b></p>	<ul style="list-style-type: none"> <li>• Please check the appropriate box corresponding to the HIV infection status of the child’s biological mother</li> <li>• If the child’s biological mother is infected, check the appropriate box regarding the timing of her diagnosis with HIV infection/AIDS</li> <li>• Please enter the date of mother’s first positive HIV confirmatory test. Record date in the month/year format. If a year is present without a designated month, enter “99” as the month followed by the documented year.</li> </ul> <p><b>Mother’s Transmission Risks (left column)</b></p> <ul style="list-style-type: none"> <li>• Check the appropriate box if mother was counseled about HIV testing during this pregnancy, labor or delivery</li> <li>• Please discuss the entire patient history section with the patient and select a response for each line. If patient indicates “unknown,” please make sure to mark that response.</li> <li>• If reporting heterosexual contact, make sure all fields under the “heterosexual relations” section are complete</li> <li>• <b>Note:</b> Risk information is critically important to helping target limited prevention funds for populations most at risk. Do not leave any line blank.</li> <li>• Obtaining risk information can sometimes be difficult or uncomfortable. If you would like assistance with completing this section, a risk assessment form can be provided for the biological mother to complete. If you would like to use this form, please call the HIV Epi Team office to obtain a copy or you can also download the form on our website: <a href="http://health.state.ga.us/epi/hiv/aids/reportinginformation.asp">http://health.state.ga.us/epi/hiv/aids/reportinginformation.asp</a></li> </ul> <p><b>Child’s Transmission Risks (right column)</b></p> <ul style="list-style-type: none"> <li>• Check all transmission risks that apply to the child. It may be necessary to talk with a parent or guardian to obtain this information.</li> <li>• Please check a response for each line.</li> <li>• <b>Note:</b> You may need to refer to the child’s medical chart to obtain any missing information.</li> </ul>
<p><b>SECTION VI STATE/LOCAL USE ONLY</b></p>	<ul style="list-style-type: none"> <li>• Document the physician’s name (pediatrician or primary care provider), phone number, and name of the hospital/facility submitting the report. Please include the name and phone number of the person completing the form. If available, record the medical record number of the child.</li> </ul>
<p><b>SECTION VII LABORATORY DATA</b></p>	<p><b>NOTE:</b> Please include the month/year for all laboratory tests as dates are required for reporting purposes. Test date refers to the specimen collection date. Oral reports of prior laboratory test results are not acceptable.</p> <p><b>HIV Antibody Tests at Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Please check a box for each line</li> <li>• Please enter a test result (pos, neg, indet) and date (month/year) for any antibody test performed</li> </ul> <p><b>HIV Detection Tests</b></p> <ul style="list-style-type: none"> <li>• Please check a box for each line</li> </ul>

	<ul style="list-style-type: none"> <li>• Please enter a test result (pos, neg) and date (month/year) for any HIV detection test performed</li> <li>• Qualitative HIV viral load tests are documented as either positive or negative</li> </ul> <p><b>HIV Viral Load Test</b></p> <ul style="list-style-type: none"> <li>• Enter both the earliest and most recent <u>detectable</u> viral load test values, dates, and specify the test type. If there are no detectable viral load tests or only one, please record these instead and indicate that they were not detectable. The test type is the same as the test name and can be located on the laboratory result. When indicating a detectable viral load, enter the test results in copies/ml and date performed. Codes for the test type are located above the boxes for viral load values. <i>Type: 11.NASBA (Organon) 12.RT-PCR (Roche) 13. bDNA (Chiron) 18. Other</i></li> </ul> <p><b>Immunologic Lab Tests</b></p> <ul style="list-style-type: none"> <li>• Please enter the earliest and most recent CD4 cell counts, percents, and test dates.</li> <li>• If there is no documentation of positive laboratory tests, please indicate if the patient has been determined by a physician to be either HIV infected or uninfected based upon history <u>and</u> symptomatology. Patient self-report is not considered a “physician diagnosis.”</li> </ul>
<p><b>SECTION VIII CLINICAL STATUS</b></p>	<ul style="list-style-type: none"> <li>• For AIDS reports, check all known indicator diseases and enter dates of diagnoses. Specify whether the diagnosis is presumptive or definitive. (Definitive diagnoses are based on specific laboratory methods, while presumptive diagnoses are those made by the clinician. A complete listing may be found in the <b>MMWR</b> supplement No.RR-12, Vol.43, September 30, 1994)</li> <li>• Please indicate if the child had been diagnosed with pulmonary tuberculosis. If yes, indicate the initial diagnosis and the date.</li> <li>• “RVCT Case No” is a field reserved for State Health Department usage.</li> </ul>
<p><b>SECTION IX BIRTH HISTORY</b></p>	<p><b>COMPLETE THIS SECTION FOR PERINATAL CASES <u>ONLY</u></b></p> <ul style="list-style-type: none"> <li>• Please indicate if a birth history is available. If yes, please complete this section of the case report form. If no, skip to Section X.</li> </ul> <p><b>Hospital at birth</b></p> <ul style="list-style-type: none"> <li>• Please record the name and location of hospital at birth.</li> </ul> <p><b>Residence at birth</b></p> <ul style="list-style-type: none"> <li>• Enter the city, county, state/country, and zip code of the residence at birth.</li> </ul> <p><b>Birth weight</b></p> <ul style="list-style-type: none"> <li>• Document the birth weight in lbs/oz or grams.</li> </ul>

	<p><b>Type of Birth and Delivery</b></p> <ul style="list-style-type: none"> <li>• Please check appropriate box for type of birth and delivery</li> <li>• <b>Note:</b> Elective caesarean is considered a caesarean section that occurs before rupture of membranes and before the onset of labor.</li> </ul> <p><b>Birth defects</b></p> <ul style="list-style-type: none"> <li>• Please record whether the child was born with any birth defects. If yes, specify the type(s) and ICD-9 code. (This information is possibly available on the birth hospital face sheet).</li> </ul> <p><b>Neonatal Status</b></p> <ul style="list-style-type: none"> <li>• Indicate whether the child was full term (greater than or equal to 37 weeks) or premature (less than 37 weeks) and record the child's gestational age</li> </ul> <p><b>Prenatal Care</b></p> <ul style="list-style-type: none"> <li>• Please enter the month of pregnancy that prenatal care began (01 to 09) and the total number of prenatal care visits. If prenatal care is not documented or unknown, enter "99." For no prenatal care, enter "00."</li> </ul> <p><b>Antiretroviral Therapy</b></p> <ul style="list-style-type: none"> <li>• Please indicate whether the mother received zidovudine (ZDV, AZT) during pregnancy.</li> <li>• If the mother received zidovudine (ZDV, AZT), enter the week of pregnancy in which zidovudine therapy was started. (If information about the pregnancy is unavailable, please use the Comments section to enter the name of the obstetrician or the name of the mother's infectious disease doctor).</li> <li>• Check the appropriate box for whether the mother received zidovudine (ZDV, AZT) during labor/delivery.</li> <li>• Check the appropriate box for whether the mother received zidovudine (ZDV, AZT) prior to this pregnancy.</li> <li>• Check the appropriate box for whether the mother received any other antiretroviral medication during pregnancy. If yes, specify the name of the medication received.</li> <li>• Check the appropriate box for whether the mother received any other antiretroviral medication during labor/delivery. If yes, specify the name of the medication received.</li> </ul> <p><b>Maternal Information</b></p> <ul style="list-style-type: none"> <li>• Be sure to include the name, date of birth, and birthplace of the biological mother.</li> <li>• <b>Note:</b> Please record the mother's name on the line next to the Maternal Soundex. The boxes for Maternal Soundex and Maternal State Patient No. should be left blank.</li> </ul>
<p><b>SECTION X TREATMENT/ REFERRALS</b></p>	<ul style="list-style-type: none"> <li>• Please check the appropriate boxes for whether the child has received or is receiving medication. Record when a specific therapy was started in the month, day, and year format. Enter "99" if month or day are unknown, followed by the year.</li> </ul>

	<ul style="list-style-type: none"><li>• Please check the appropriate box if the child was breast-fed.</li><li>• Please document, if known, clinical trial enrollment, medical treatment reimbursement, and child's primary care taker.</li></ul>
<b>SECTION XI COMMENTS</b>	<ul style="list-style-type: none"><li>• If available, please write in any additional lab or clinical information.</li><li>• <b>Document any additional names used by mother or child that are different from Section I</b> (i.e., mother's married/maiden names, adoptive name changes, etc). If known, write in the names of siblings, ages, DOB's, and birth hospitals.</li></ul>