**Note on using the modifiable version of the form:**

If changes are made to the form, please remove the OMB approval number, OMB expiration date, CDC form number, and CDC revision date. A notation that the form is adapted from the relevant CDC form number and revision date can be included.

# 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** | | | **\*ZIP Code** |
| **\*Medical Record Number** | | | | | **\*Other ID Type \*Number** | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **U.S. Department of Health and Human Services** | **Pediatric HIV Confidential Case Report Form** | **Centers for Disease Control and Prevention (CDC)** |
| **(Patients aged <13 years at time of perinatal exposure or patients aged <13 years at time of diagnosis) \*Information NOT transmitted to 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 □** 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** | *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**  ( ) | |

# 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 □** US **□** Other/US dependency  **Birth** (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 seroreverter | | * 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** | |

|  |
| --- |
| 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 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  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/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** | **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, pulmonary1 |  |
| Candidiasis, esophageal |  | Histoplasmosis, disseminated or extrapulmonary |  | M. tuberculosis, disseminated or extrapulmonary1 |  |
| 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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 provider2 **□** 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** |

# 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**  (if child was born at home, enter “home birth”) | | | | | | | | | | | **\*Phone**  ( ) |
| **Facility Type** *Inpatient:* **□** Hospital *Outpatient: Other Facility*: **□** Emergency room **□** Corrections **□** Unknown   * Other, specify **□** Other, specify **□** 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) | | **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. 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**  Live birth Miscarriage or Stillbirth Induced abortion (9999 = Unknown)  i. **□ □ □**  ii. **□ □ □**  iii. **□ □ □**  iv. **□ □ □**  v. **□ □ □**  (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**  **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 birthing person during this pregnancy or at the time of labor and delivery?**  **Yes Date of diagnosis** (mm/dd/yyyy) **No Unknown**  Bacterial vaginosis □ / / □ □  *Chlamydia trachomatis* infection □ / / □ □  Genital herpes □ / / □ □  Gonorrhea □ / / □ □  Group B strep □ / / □ □  Hepatitis B (HBsAg) □ / / □ □  Hepatitis C □ / / □ □  PID □ / / □ □  Syphilis □ / / □ □  Trichomoniasis □ / / □ □ | | | | | | | | |
| **Were substances used by the birthing person 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. Birthing Person History (for patients exposed perinatally with or without consequent infection) *(cont)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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) | | | | | |
|  | **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

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|  |

# XIV. \*Local/Optional Fields

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