## 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

(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 ☐ 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 Birth ☐ US ☐ Other/US dependency (specify) _____ |
|---|---|---|
| | | |

| Date of Birth __ __/__ __/__ __ __ __ | Alias Date of Birth __ __/__ __/__ __ __ __ |
|---|---|
| | |

| Vital Status ☐ 1-Alive ☐ 2-Dead | Date of Death __ __/__ __/__ __ __ __ | State of Death |
|---|---|---|
| | | |

| Date of Last Medical Evaluation __ __/__ __/__ __ __ __ | Date of Initial Evaluation for HIV __ __/__ __/__ __ __ __ |
|---|---|
| | |

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 |
|---|---|---|---|
| | | | |

## 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)<br>First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __ | ☐ Yes ☐ No ☐ Unknown |
| 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<br>Specify clotting factor: Date received __ __ /__ __ /__ __ __ __ | ☐ Yes ☐ No ☐ Unknown |
| Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)<br>First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __ | ☐ Yes ☐ No ☐ Unknown |
| 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, 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 | |

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

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

**HIV Immunoassays**

**TEST** ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-2 IA
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1/2 Ag/Ab differentiating immunoassay (differentiates between HIV Ag and HIV Ab)
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ***Overall:*** ☐ Reactive ☐ Nonreactive **Collection Date** __ __ /__ __ /__ __ __ __
***Analyte results:*** HIV-1 Ag: ☐ Reactive ☐ Nonreactive HIV-1/2 Ab: ☐ Reactive ☐ Nonreactive
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1/2 Ag/Ab and type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result**[3] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index Value** _____ **Collection Date** __ __ /__ __ /__ __ __ __
***Analyte results***: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index Value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index Value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index Value** _____
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1/2 type-differentiating immunoassay (supplemental) (differentiates between HIV-1 Ab and HIV-2 Ab)
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result**[4] ***Overall interpretation***: ☐ HIV positive, untypable ☐ HIV-1 positive with HIV-2 cross-reactivity ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV negative ☐ HIV indeterminate ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV-1 positive ☐ HIV-2 positive
***Analyte results***: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 WB
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**HIV Detection Tests**

**TEST** ☐ HIV-1/2 RNA NAAT (Qualitative) **Lab Name** _____
**Test Brand Name/Manufacturer** _____ **Provider Name** _____
**Facility Name** _____ **Collection Date** __ __ /__ __ /__ __ __ __
**Result** ☐ HIV-1 ☐ HIV-2 ☐ Both (HIV-1 and HIV-2) ☐ HIV, not differentiated (HIV-1 or HIV-2) ☐ Neither (negative)
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1 RNA NAAT (Qualitative and Quantitative)
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ***Qualitative:*** ☐ Reactive ☐ Nonreactive **Collection Date** __ __ /__ __ /__ __ __ __
***Analyte results:*** HIV-1 Quantitative: ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit
**Copies/mL** _____ **Log** _____
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**TEST** ☐ HIV-1 RNA/DNA NAAT (Quantitative) ☐ HIV-2 RNA/DNA NAAT (Quantitative)
**Test Brand Name/Manufacturer** _____ **Lab Name** _____
**Facility Name** _____ **Provider Name** _____
**Result** ☐ Detectable above limit ☐ Detectable within limits ☐ Detectable below limit ☐ Not detected **Copies/mL** _____ **Log** _____
**Collection Date** __ __ /__ __ /__ __ __ __
**Testing Option** (if applicable) ☐ Point-of-care test by provider ☐ Self-test, result directly observed by a provider[2] ☐ Lab test, self-collected sample

**Drug Resistance Tests (Genotypic)**

**TEST** ☐ HIV-1 Genotype (Unspecified) **Test Brand Name/Manufacturer** _____
**Lab Name** _____ **Facility Name** _____
**Provider Name** _____ **Collection Date** __ __ /__ __ /__ __ __ __

**Immunologic Tests (CD4 count and percentage)**

**CD4 count** _____ cells/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** __ __/__ __/__ __ __ __ |

[2]Results not directly observed by a provider should be recorded in HIV Testing History.
[3]Complete the overall interpretation and the analyte results.
[4]Always complete the overall interpretation. Complete the analyte results when available.

## X. Birth History (for patients exposed perinatally with or without consequent infection)

**Birth history available?** ☐ Yes ☐ No ☐ Unknown

**Residence at Birth** ☐ Check if SAME as current address

**Address Type** ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

| ***Street Address** | **City** | |
|---|---|---|
| **County** | **State/Country** | ***ZIP Code** |

**Facility of Birth** ☐ Check if SAME as facility providing information

| **Facility Name of Birth** (if child was born at home, enter "home birth") | ***Phone** ( ) |
|---|---|

**Facility Type** *Inpatient*: ☐ Hospital ☐ Other, specify_____ *Outpatient:* ☐ 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 ☐ 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)

| | Not screened | Date of screen | Result: Positive | Result: Negative | Result: 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** (9999 = Unknown) |
|---|---|---|---|---|
| | Live birth | Miscarriage or Stillbirth | Induced abortion | |
| 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

☐ **Check OOS State: _____** **If pregnant, list EDD (due date): _____/_____/_____**

☐ **DOC#_____**

**Link with e-HARS Stateno(s):**

## XIV. *Local/Optional Fields

**NIR Status:**

**STARS: _____**

**Other Risks: A** ☐ **B/C** ☐ **D** ☐ **F** ☐ **M** ☐ **V** ☐ **J** ☐ **O** ☐

**Hepatitis: A** ☐ **B** ☐ **C** ☐ **Other** ☐ **UNKnown** ☐

**NIR OP _____ Date: _____/_____/_____**

**NIR RE _____ Date: _____/_____/_____**

**NIR CL _____ Date: _____/_____/_____**

**Initials (3) _____ Source code: _____**