HIV Surveillance Program

Bureau of HIV/STI/Viral Hepatitis

Ohio Department of Health

OHIO PEDIATRIC HIV CASE REPORT FORM

(Patients < 13 Years of Age at Time of Diagnosis)

PATIENT IDENTIFICATION

First Name:	Middle Name:	Last Name:	Alias:

Address Type: ☐ Residential ☐ Foster Home ☐ Unhoused ☐ Unknown ☐ Other (Specify):

Street Address:

City:	County:	State / Country:	ZIP:

Is the current address the address at birth? ☐ Yes ☐ No

If NO, list the birth address:

Phone:	Social Security # (Last Four):	Medical Record Number:

PATIENT DEMOGRAPHICS

Date of Birth:	Sex at Birth: ☐ Male ☐ Female ☐ Unknown	Vital Status: ☐ Alive ☐ Dead	Date of Death:

Country of Birth: ☐ US ☐ Other - Specify:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Race (Check all that apply): ☐ American Indian / Alaskan Native ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ Middle Eastern or North African ☐ Asian ☐ White ☐ Other ☐ Unknown

This Child's Primary Caretaker is: ☐ Biological Parent ☐ Other Relative ☐ Foster / Adoptive Parent, Relative ☐ Foster / Adoptive Parent, Unrelated ☐ Social Service Agency ☐ Unknown ☐ Other (Specify):

PREVIOUS POSITIVE INFORMATION (Only fill out if patient has previously tested positive for HIV)

Diagnosis Date:	State / Country of Diagnosis:	Diagnosing Facility:

LABORATORY DATA

Ordering Provider:	Ordering Facility:	Performing Laboratory:

HIV Screening Test at Diagnosis:

HIV-1/2 Screening: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

Point-of-Care Rapid HIV Test: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Confirmation / Differentiation (Geenius):

HIV-1: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV-2: ☐ POS ☐ NEG ☐ IND — **Collection Date:**

HIV Viral Load Test - Quantitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D — **Copies/ml:** — ☐ ND — **Collection Date:**

HIV Detection Tests - Qualitative (D = Detected, ND = Not Detected):

HIV-1 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

HIV-2 RNA/DNA NAAT: ☐ D ☐ ND — **Collection Date:**

CD4 Tests:

Count:	Percent: %	Collection Date:

Resistance Tests:

Genotype Test Done? ☐ Yes ☐ No ☐ Unknown — **Collection Date:**

Other HIV Testing (Enter Any Additional HIV Tests):

Test Type:	Result:	Collection Date:

Past HIV Testing

Has the child ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown

If YES, date of the most recent negative test:

TREATMENT HISTORY

Has the child ever taken any antiretroviral medications (ARVs)? ☐ Yes ☐ No ☐ Unknown — **If YES, Date Last Taken:**

ARVs Currently Taking (List All):

Has the child ever taken PCP prophylaxis? ☐ Yes ☐ No ☐ Unknown — **If YES, Date PCP Began:** — **Date Last Used:**

PATIENT HISTORY

Child breastfed by birth mother? ☐ Yes ☐ No ☐ Unknown | **If YES, Start Date:** | **Stop Date:**

Before the diagnosis of HIV infection, this child had:

- **Injected nonprescription drugs.** ☐ Yes ☐ No ☐ Unknown
- **Received clotting factor for hemophilia/coagulation disorder/blood transfusion/tissue or organ transplant.** ☐ Yes ☐ No ☐ Unknown
- **Sexual contact with a male.** ☐ Yes ☐ No ☐ Unknown
- **Other-specify:**

BIRTH HISTORY

Birth Weight: lbs oz grams | **Type of Birth:** ☐ Single ☐ Twin ☐ More than Two ☐ Unknown

Delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown

Congenital Disorders: ☐ Yes (Specify): ☐ No ☐ Unknown

Neonatal Status: ☐ Full Term ☐ Premature ☐ Unknown

BIRTH MOTHER'S HISTORY (For patients exposed perinatally with or without consequent infection.)

Birth Mother's Name:	Birth Mother's Date of Birth:	Birth Mother's First HIV+ Test Date:

Month into Pregnancy Prenatal Care Began (1-9): [Select] | **Total Number of Prenatal Care Visits:**

Did the birth mother receive any antiretrovirals (ARVs) PRIOR to pregnancy? ☐ Yes ☐ No ☐ Unknown

If YES, Date ARV Use Began:	Date of Last ARV Use:	ARVs Taken (List All):

Did the birth mother receive any ARVs DURING this pregnancy? ☐ Yes ☐ No ☐ Unknown

If YES, Date ARV Use Began:	Date of Last ARV Use:	ARVs Taken (List All):

If NO, Select Reason: ☐ HIV serostatus of birth mother unknown. ☐ Birth mother known to be HIV-negative during pregnancy. ☐ No prenatal care ☐ Unknown ☐ Other (Specify):

Did the birth mother receive any ARVs DURING labor/delivery? ☐ Yes ☐ No ☐ Unknown

If YES, Date ARV Use Began:	Date of Last ARV Use:	ARVs Taken (List All):

If NO, Select Reason: ☐ Precipitous delivery/STAT Cesarean delivery. ☐ Birth mother testing HIV negative during pregnancy. ☐ HIV serostatus of birthing person. ☐ Birth not in hospital. ☐ Unknown ☐ Other (Specify):

FACILITY PROVIDING INFORMATION

Facility Name:		Street Address:	
City:	County:	State:	Zip Code:
Name of Provider that Ordered HIV Diagnostic Tests:		Specialty:	Phone Number:

Is the providing facility also the birthing facility? ☐ Yes ☐ No | **If NO, birthing facility:**

Is the providing facility also the diagnosing facility? ☐ Yes ☐ No | **If NO, diagnosing facility:**

PERSON PROVIDING INFORMATION

Date Form Completed:	Person Completing Form:	Phone Number/Email:

COMMENTS SECTION

Provide any additional information about the patient:

Complete and submit the case form by one of the following methods:

Fax: 614-388-9782

Mail the report form in an envelope marked "Confidential" to:

Ohio Department of Health
HIV Surveillance Program
246 N. High St
Columbus, OH 43215

If you have any questions, email HIVsurveillance@odh.ohio.gov.

All confirmed cases of HIV, including Stage 3 (AIDS), and all instances of perinatal exposure to HIV are required to be reported by healthcare providers and laboratories to the designated health authorities per Ohio Administrative Code 3701-3-12.