

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

I. Patient Identification (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 02/28/2026

*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		Correctional facility		Homeless		Other	
Bad address		Foster home		Military		Postal	
Shelter		Temporary					
*Current Address, Street						Address Date	
						/ /	
*Phone		City		County		State/Country	
						*ZIP Code	
*Medical Record Number		*Other ID Type		*Number			

II. Health Department Use Only (record all dates as mm/dd/yyyy)

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?		Report Medium			
Yes No Unknown		1-Field visit 3-Faxed 5-Electronic transfer			
		2-Mailed 4-Phone 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					
<u>Inpatient:</u>		<u>Outpatient:</u>		<u>Other Facility:</u>	
Hospital		Private physician's office		Emergency room	
Other, specify		Pediatric clinic		Laboratory	
		Pediatric HIV clinic		Unknown	
		Other, specify		Other, specify	
Date Form Completed		*Person Completing Form		*Phone	
/ /					

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).

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		Date of Birth	Alias Date of Birth
Other/US dependency (specify) _____				____/____/____	____/____/____
Vital Status		Date of Death		State of Death	
1-Alive 2-Dead		____/____/____		_____	
Date of Last Medical Evaluation		Date of Initial Evaluation for HIV			
____/____/____		____/____/____			
Gender Identity					Date Identified
Boy					____/____/____
Girl					
Transgender boy					Additional gender identity (specify) _____
Transgender girl					Declined to answer
					Unknown
Sexual Orientation					Date Identified
Straight or heterosexual					Declined to answer
Lesbian or gay					Unknown
Bisexual					
Additional sexual orientation (specify) _____					____/____/____
Ethnicity		Hispanic/Latino	Not Hispanic/Latino	Unknown	
		Expanded Ethnicity			

Race (check all that apply)		American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander		Expanded Race
		Asian	White		_____
		Black/African American	Unknown		_____

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 seroverter	Check if <u>SAME</u> as current address
Address Type	*Street Address				
Residential	Military	_____			
Bad address	Other	City	County		
Correctional facility	Postal	_____	_____		
Foster home	Shelter	State/Country	*ZIP Code		
Homeless	Temporary	_____	_____		

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 <u>SAME</u> as facility providing information
Facility Name				*Phone
_____			_____	
*Street Address	City			
_____			_____	
County	State/Country			*ZIP Code
_____			_____	
Facility Type				
<u>Inpatient:</u>	<u>Outpatient:</u>		<u>Other Facility:</u>	
Hospital	Private physician's office		Emergency room	
Other, specify	Pediatric clinic		Laboratory	
_____	Pediatric HIV clinic		Unknown	
	Other, specify		Other, specify	
	_____		_____	
*Provider Name	*Provider Phone	Specialty		
_____	_____	_____		

VII. Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Birth 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
(If yes) Start Date ____/____/____ Stop Date ____/____/____

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	Yes	No	Unknown
Specify clotting factor: _____ Date received ____/____/____			
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
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		Lymphoid interstitial pneumonia and/or pulmonary lymphoid	
Candidiasis, bronchi, trachea, or lungs		Lymphoma, Burkitt's (or equivalent)	
Candidiasis, esophageal		Lymphoma, immunoblastic (or equivalent)	
Carcinoma, invasive cervical		Lymphoma, primary in brain	
Coccidioidomycosis, disseminated or extrapulmonary		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Cryptococcosis, extrapulmonary		M. tuberculosis, pulmonary ¹	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		M. tuberculosis, disseminated or extrapulmonary ¹	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Cytomegalovirus retinitis (with loss of vision)		Pneumocystis pneumonia	
HIV encephalopathy		Pneumonia, recurrent, in 12 mo. period	
Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		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	
Kaposi's sarcoma			

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	Collection Date	Testing Option (if applicable)				
Positive	/ /	Point-of-care test by provider				
Negative	/ /	Self-test, result directly observed by a provider ²				
Indeterminate		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	Analyte results:			Collection Date	Testing Option (if applicable)	
Overall:	HIV-1 Ag:	HIV-1/2 Ab:			Point-of-care test by provider	
Reactive	Reactive	Reactive	/ /		Self-test, result directly observed by a provider ²	
Nonreactive	Nonreactive	Nonreactive			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	Analyte results:			Collection Date		
Overall interpretation:	HIV-1 Ag:	HIV-1 Ab:	HIV-2 Ab:	/ /		
Reactive	Reactive	Reactive	Reactive			
Nonreactive	Nonreactive	Nonreactive	Nonreactive			
Index Value	Not reportable due to high Ab level	Reactive undifferentiated	Reactive undifferentiated		Testing Option (if applicable)	
	Index Value	Index Value	Index Value		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		Analyte results:		Collection Date		
Overall interpretation:		HIV-1 Ab:	HIV-2 Ab:	/ /		
HIV positive, untypable	HIV indeterminate	Positive	Positive			
HIV-1 positive with HIV-2 cross-reactivity	HIV-1 indeterminate	Negative	Negative			
HIV-2 positive with HIV-1 cross-reactivity	HIV-2 indeterminate	Indeterminate	Indeterminate		Testing Option (if applicable)	
HIV negative	HIV-1 positive				Point-of-care test by provider	
	HIV-2 positive				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		Collection Date	Testing Option (if applicable)			
Positive		/ /	Point-of-care test by provider			
Negative			Self-test, result directly observed by a provider ²			
Indeterminate			Lab test, self-collected sample			

HIV Detection Tests		TEST	HIV-1/2 RNA NAAT (Qualitative)	
Test Brand Name/Manufacturer		Lab Name		
Facility Name		Provider Name		
Result HIV-1 HIV, not differentiated (HIV-1 or HIV-2) HIV-2 Neither (negative) Both (HIV-1 and HIV-2)		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 NAAT (Qualitative and Quantitative)		
Test Brand Name/Manufacturer		Lab Name		
Facility Name		Provider Name		
Result Qualitative: Reactive Nonreactive	Analyte results: HIV-1 Quantitative Detectable above limit Detectable within limits Detectable below limit	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	

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	%
Test Brand Name/Manufacturer		Lab Name	
Facility Name		Provider Name	

Documentation of Tests

Complete 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.

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 ____/____/____

Is earliest evidence of HIV infection 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) Birthing person's or physician's preference Not specified
Previous Cesarean (repeat) Fetal distress
Malpresentation (breech, transverse) Placenta abruptia or p. previa
Prolonged labor or failure to progress Other (e.g., herpes, disproportion) (Specify) _____

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)

Substance name	Not screened	Date of screen	Result		
Alcohol		/ /	Positive	Negative	Unknown
Amphetamines		/ /	Positive	Negative	Unknown
Barbiturates		/ /	Positive	Negative	Unknown
Benzodiazepines		/ /	Positive	Negative	Unknown
Cocaine		/ /	Positive	Negative	Unknown
Crack cocaine		/ /	Positive	Negative	Unknown
Fentanyl		/ /	Positive	Negative	Unknown
Hallucinogens		/ /	Positive	Negative	Unknown
Heroin		/ /	Positive	Negative	Unknown
K2		/ /	Positive	Negative	Unknown
Marijuana (cannabis, THC, cannabinoids)		/ /	Positive	Negative	Unknown
Methadone		/ /	Positive	Negative	Unknown
Methamphetamines		/ /	Positive	Negative	Unknown
Nicotine (any tobacco)		/ /	Positive	Negative	Unknown
Opiates		/ /	Positive	Negative	Unknown
PCP		/ /	Positive	Negative	Unknown
Other, specify		/ /	Positive	Negative	Unknown
Specific drug(s) not documented		/ /	Positive	Negative	Unknown

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

(Record additional pregnancy outcomes in Comments)

If YES, specify how many previous pregnancies

	Pregnancy outcome (select one)				Year outcome occurred (9999 = Unknown)
1	Live Birth	Miscarriage or Stillbirth	Induced abortion		
2	Live Birth	Miscarriage or Stillbirth	Induced abortion		
3	Live Birth	Miscarriage or Stillbirth	Induced abortion		
4	Live Birth	Miscarriage or Stillbirth	Induced abortion		
5	Live Birth	Miscarriage or Stillbirth	Induced abortion		

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

Condition name	Was condition screened?			
Group B strep	Yes, Date of screen (mm/dd/yyyy) / /	No	Unknown	
Hepatitis B (HBsAg)	Yes, Date of screen (mm/dd/yyyy) / /	No	Unknown	
Rubella	Yes, Date of screen (mm/dd/yyyy) / /	No	Unknown	
Syphilis	Yes, Date of screen (mm/dd/yyyy) / /	No	Unknown	

Were any of the following conditions diagnosed for the birthing person during this pregnancy or at the time of labor and delivery?

Condition name	Was condition diagnosed?			
Bacterial vaginosis	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
<i>Chlamydia trachomatis</i> infection	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Genital herpes	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Gonorrhea	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Group B strep	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Hepatitis B (HBsAg)	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Hepatitis C	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
PID	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Syphilis	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	
Trichomoniasis	Yes, Date of diagnosis (mm/dd/yyyy) / /	No	Unknown	

Were substances used by the birthing person during this pregnancy? Yes No Unknown

Substance name	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					

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)

Substance name	Not screened	Date of screen	Result		
Alcohol		/ /	Positive	Negative	Unknown
Amphetamines		/ /	Positive	Negative	Unknown
Barbiturates		/ /	Positive	Negative	Unknown
Benzodiazepines		/ /	Positive	Negative	Unknown
Cocaine		/ /	Positive	Negative	Unknown
Crack cocaine		/ /	Positive	Negative	Unknown
Fentanyl		/ /	Positive	Negative	Unknown
Hallucinogens		/ /	Positive	Negative	Unknown
Heroin		/ /	Positive	Negative	Unknown
K2		/ /	Positive	Negative	Unknown
Marijuana (cannabis, THC, cannabinoids)		/ /	Positive	Negative	Unknown
Methadone		/ /	Positive	Negative	Unknown
Methamphetamines		/ /	Positive	Negative	Unknown
Nicotine (any tobacco)		/ /	Positive	Negative	Unknown
Opiates		/ /	Positive	Negative	Unknown
PCP		/ /	Positive	Negative	Unknown
Other, specify _____		/ /	Positive	Negative	Unknown
Specific drug(s) not documented		/ /	Positive	Negative	Unknown

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
1. _____	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	/ /	/ /
	Other (specify reason) _____					/ /	/ /
2. _____	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	/ /	/ /
	Other (specify reason) _____					/ /	/ /
3. _____	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	/ /	/ /
	Other (specify reason) _____					/ /	/ /
4. _____	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	/ /	/ /
	Other (specify reason) _____					/ /	/ /
5. _____	HIV Tx	PrEP	PEP	PMTCT	HBV Tx	/ /	/ /
	Other (specify reason) _____					/ /	/ /

(Record additional ARV medications in Comments)

Has this child ever taken PCP prophylaxis Yes No Unknown

This child's primary caretaker is

- 1-Biological parent 3- Foster/Adoptive parent, relative 7-Social service agency 9-Unknown
 2-Other relative 4- Foster/Adoptive parent, unrelated 8-Other (specify in comments)

XIII. Comments

XIV. *Local/Optional Fields