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 **(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 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, 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 **Not HIV-infected** ☐ Yes ☐ No ☐ Unknown	**Date of diagnosis by physician** __ __ /__ __ /__ __ __ __ **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

XIV. *Local/Optional Fields