

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 <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary			*Current Address, Street				Address Date ____/____/____		
*Phone ()		City		County		State/Country		*ZIP Code	
*Medical Record Number				*Other ID Type Social Security		*Number			

U.S. Department of Health
and Human Services**Pediatric HIV Confidential Case Report Form**
(Patients aged <13 years at time of diagnosis) *Information NOT transmitted to CDCCenters for Disease Control
and Prevention (CDC)**Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 11/30/2022

Date Received at Health Department ____/____/____		eHARS Document UID			State Number		
Reporting Health Dept—City/County				City/County Number			
Document Source			Surveillance Method <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown				
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Report Medium <input type="checkbox"/> 1-Field visit <input type="checkbox"/> 2-Mailed <input type="checkbox"/> 3-Faxed <input type="checkbox"/> 4-Phone <input type="checkbox"/> 5-Electronic transfer <input type="checkbox"/> 6-CD/disk				

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name					*Phone ()		
*Street Address							
City		County		State/Country		*ZIP Code	
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <i>Outpatient:</i> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____							
Date Form Completed ____/____/____			*Person Completing Form			*Phone ()	

Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report <input type="checkbox"/> 3-Perinatal HIV exposure <input type="checkbox"/> 4-Pediatric HIV <input type="checkbox"/> 5-Pediatric AIDS <input type="checkbox"/> 6-Pediatric seroreverter			Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Country of Birth <input type="checkbox"/> US <input type="checkbox"/> Other/US dependency (please specify) _____		
Date of Birth ____/____/____				Alias Date of Birth ____/____/____			
Vital Status <input type="checkbox"/> 1-Alive <input type="checkbox"/> 2-Dead		Date of Death ____/____/____			State of Death		
Date of Last Medical Evaluation ____/____/____				Date of Initial Evaluation for HIV ____/____/____			
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown					Expanded Ethnicity		
Race (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown					Expanded Race		

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) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at stage 3 (AIDS) diagnosis <input type="checkbox"/> Residence at perinatal exposure <input type="checkbox"/> Residence at pediatric seroreverter <input type="checkbox"/> Check if SAME as current address							
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> 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 on file at the local health department, 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).

STATE/LOCAL USE ONLY	
*Provider Name (Last, First, M.I.)	*Phone ()
Hospital/Facility	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> Stage 3 (AIDS) <input type="checkbox"/> Perinatal exposure <input type="checkbox"/> 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> <input type="checkbox"/> Hospital <u>Outpatient:</u> <input type="checkbox"/> Private physician's office <input type="checkbox"/> Pediatric clinic <u>Other Facility:</u> <input type="checkbox"/> Emergency room <input type="checkbox"/> Laboratory <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Pediatric HIV clinic <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____			
*Provider Name		*Provider Phone ()	Specialty

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

Child's biological mother's HIV infection status (select one): <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be uninfected after this child's birth <input type="checkbox"/> Known HIV+ before pregnancy <input type="checkbox"/> Known HIV+ during pregnancy <input type="checkbox"/> Known HIV+ sometime before birth <input type="checkbox"/> Known HIV+ at delivery <input type="checkbox"/> Known HIV+ after child's birth <input type="checkbox"/> HIV+, time of diagnosis unknown <input type="checkbox"/> HIV status unknown	
Date of mother's first positive test to confirm infection ____ / ____ / _____	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Biological mother had:	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____ / ____ / _____ Last date received ____ / ____ / _____	
Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Before the diagnosis of HIV infection, this child had:	
Injected nonprescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specify clotting factor: _____ Date received ____ / ____ / _____	
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ____ / ____ / _____ Last date received ____ / ____ / _____	
Received transplant of tissue/organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with male	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sexual contact with female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other documented risk (please include detail in Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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	

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

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

HIV Immunoassays (Nondifferentiating)			
TEST 1 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____ <input type="checkbox"/> Point-of-care rapid test	
TEST 2 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____ <input type="checkbox"/> Point-of-care rapid test	
HIV Immunoassays (Differentiating)			
<input type="checkbox"/> HIV-1/2 type-differentiating immunoassay (differentiates between HIV-1 Ab and HIV-2 Ab)		Role of test in diagnostic algorithm <input type="checkbox"/> Screening/initial test <input type="checkbox"/> Confirmatory/supplemental test	
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result ¹ Overall interpretation: <input type="checkbox"/> HIV-1 positive <input type="checkbox"/> HIV-2 positive <input type="checkbox"/> HIV positive, untypable <input type="checkbox"/> HIV-2 positive with HIV-1 cross-reactivity <input type="checkbox"/> HIV-1 indeterminate <input type="checkbox"/> HIV-2 indeterminate <input type="checkbox"/> HIV indeterminate <input type="checkbox"/> HIV negative		Collection Date ____/____/____ <input type="checkbox"/> Point-of-care rapid test	
Analyte results: HIV-1 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate HIV-2 Ab: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		¹ Always complete the overall interpretation. Complete the analyte results when available.	
<input type="checkbox"/> 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 <input type="checkbox"/> Ag positive <input type="checkbox"/> Ab positive <input type="checkbox"/> Both (Ag and Ab positive) <input type="checkbox"/> Negative <input type="checkbox"/> Invalid		Collection Date ____/____/____ <input type="checkbox"/> Point-of-care rapid test	
<input type="checkbox"/> 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 ² Overall interpretation: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Index value _____		Collection Date ____/____/____ <input type="checkbox"/> Point-of-care rapid test ² Complete the overall interpretation and the analyte results.	
Analyte results: HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not reportable due to high Ab level Index value _____ HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index value _____ HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Reactive undifferentiated Index value _____			
HIV Detection Tests (Qualitative)			
TEST <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-1 culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qualitative) <input type="checkbox"/> HIV-2 culture			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date ____/____/____	
HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis.			
TEST 1 <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL _____		Log _____ Collection Date ____/____/____	
TEST 2 <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Result <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL _____		Log _____ Collection Date ____/____/____	
Drug Resistance Tests (Genotypic)			
TEST <input type="checkbox"/> HIV-1 Genotype (Unspecified)			
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Collection Date ____/____/____			
Immunologic Tests (CD4 count and percentage)			
CD4 at or closest to diagnosis: CD4 count _____ cells/ μ L		CD4 percentage _____ % Collection Date ____/____/____	
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
First CD4 result <200 cells/ μ L or <14%: CD4 count _____ cells/ μ L		CD4 percentage _____ % Collection Date ____/____/____	
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Other CD4 result: CD4 count _____ cells/ μ L		CD4 percentage _____ % Collection Date ____/____/____	
Test brand name/Manufacturer _____		Lab name _____	
Facility name _____		Provider name _____	
Documentation of Tests			
Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, provide specimen collection date of earliest positive test for this algorithm ____/____/____			
Complete the above only if none of the following were positive for HIV-1: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.			
If laboratory tests were not documented, is patient confirmed by a physician as		HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of diagnosis ____/____/____	
		Not HIV-infected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of diagnosis ____/____/____	

Birth History (for Perinatal Cases only)

Birth history available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Residence at Birth <input type="checkbox"/> Check if <u>SAME</u> as current address			
Address Type <input type="checkbox"/> Residential <input type="checkbox"/> Bad address <input type="checkbox"/> Correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary			
*Street Address			City
County		State/Country	*ZIP Code
Facility of Birth <input type="checkbox"/> Check if <u>SAME</u> as facility providing information			
Facility Name of Birth (if child was born at home, enter "home birth")			*Phone ()
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<i>Outpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	
		<i>Other Facility:</i> <input type="checkbox"/> Emergency room <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	
*Street Address			City
County		State/Country	*ZIP Code
Birth History		Birth Weight ___ lbs ___ oz ___ grams	Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3-More than two <input type="checkbox"/> 9-Unknown
Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Nonelective Cesarean <input type="checkbox"/> 4-Cesarean, unknown type <input type="checkbox"/> 9-Unknown			
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify types			
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> 9-Unknown		Neonatal Gestational Age in Weeks (99 = Unknown, 00 = None)	
Prenatal Care—Month of Pregnancy Prenatal Care Began (99 = Unknown, 00 = None)		Prenatal Care—Total Number of Prenatal Care Visits (99 = Unknown, 00 = None)	
Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/___ Date of last use ___/___/___			If yes, specify all ARVs
Did mother receive any ARVs during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/___ Date of last use ___/___/___			If yes, specify all ARVs
Did mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown Date began ___/___/___ Date of last use ___/___/___			If yes, specify all ARVs
Maternal Information		Maternal DOB ___/___/___	Maternal Last Name Soundex
Maternal State ID Number		Maternal Country of Birth	
*Other Maternal ID (specify type of ID and ID number)			

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

This child ever taken any ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, reason for ARV use (select all that apply)			
<input type="checkbox"/> HIV Tx	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
<input type="checkbox"/> PrEP	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
<input type="checkbox"/> PEP	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
<input type="checkbox"/> PMTCT	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
<input type="checkbox"/> HBV Tx	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
<input type="checkbox"/> Other (specify reason) _____	ARV medications _____	Date began ___/___/___	Date of last use ___/___/___
Has this child ever taken PCP prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date began ___/___/___	Date of last use ___/___/___
Was this child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
This child's primary caretaker is <input type="checkbox"/> 1-Biological parent <input type="checkbox"/> 2-Other relative <input type="checkbox"/> 3-Foster/Adoptive parent, relative <input type="checkbox"/> 4-Foster/Adoptive parent, unrelated <input type="checkbox"/> 7-Social service agency <input type="checkbox"/> 8-Other (please specify in comments) <input type="checkbox"/> 9-Unknown			

Comments

CHECK OOS STATE: _____

Local/Optional Fields*NIR STATUS:**

STARS#	NIR OP ___ Date ___/___/___
Link with e-HARS stateno (s):	NIR CL ___ Date ___/___/___
Hepatitis: A ___ B ___ C ___ Other ___ Unknown ___	NIR RE ___ Date ___/___/___
	Initials(3)____ Source code:____