

**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

<b>*First Name</b>		<b>*Middle Name</b>		<b>*Last Name</b>		<b>Last Name Soundex</b>
<b>Alternate Name Type</b> (example: Birth, Call Me)		<b>*First Name</b>	<b>*Middle Name</b>	<b>*Last Name</b>		
<b>Address Type</b>						
Residential	Correctional facility	Homeless	Other	Shelter		
Bad address	Foster home	Military	Postal	Temporary		
<b>*Current Address, Street</b>						<b>Address Date</b> / /
<b>*Phone</b>	<b>City</b>	<b>County</b>	<b>State/Country</b>		<b>*ZIP Code</b>	
<b>*Medical Record Number</b>		<b>*Other ID Type</b>		<b>*Number</b>		

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

<b>Date Received at Health Department</b> / /		<b>eHARS Document UID</b>		<b>State Number</b>		
<b>Reporting Health Dept—City/County</b>			<b>City/County Number</b>			
<b>Document Source</b>		<b>Surveillance Method</b>				
		Active	Passive	Follow up	Reabstraction	Unknown
<b>Did this report initiate a new case investigation?</b>		<b>Report Medium</b>				
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)

<b>Facility Name</b>				<b>*Phone</b>	
<b>*Street Address</b>			<b>City</b>		
<b>County</b>		<b>State/Country</b>		<b>*ZIP Code</b>	
<b>Facility Type</b>					
<u>Inpatient:</u>		<u>Outpatient:</u>		<u>Other Facility:</u>	
Hospital	Private physician's office	Pediatric HIV clinic		Emergency room	Unknown
Other, specify	Pediatric clinic	Other, specify		Laboratory	Other, specify
<b>Date Form Completed</b> / /		<b>*Person Completing Form</b>			<b>*Phone</b>

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)

<b>Diagnostic Status at Report</b>	3-Perinatal HIV exposure	4-Pediatric HIV	5-Pediatric AIDS	6-Pediatric seroreverter
<b>Sex Assigned at Birth</b>	Male	Female	Unknown	
<b>Country of Birth</b>	US		<b>Date of Birth</b>	<b>Alias Date of Birth</b>
	Other/US dependency (specify) _____		____/____/____	____/____/____
<b>Vital Status</b>	1-Alive	2-Dead	<b>Date of Death</b>	<b>State of Death</b>
			____/____/____	_____
<b>Date of Last Medical Evaluation</b>		<b>Date of Initial Evaluation for HIV</b>		
____/____/____		____/____/____		
<b>Gender Identity</b>	Boy			<b>Date Identified</b>
	Girl	Additional gender identity (specify) _____		____/____/____
	Transgender boy	Declined to answer		
	Transgender girl	Unknown		
<b>Sexual Orientation</b>	Straight or heterosexual	Declined to answer		<b>Date Identified</b>
	Lesbian or gay	Unknown		____/____/____
	Bisexual			
	Additional sexual orientation (specify) _____			
<b>Ethnicity</b>	Hispanic/Latino	Not Hispanic/Latino	Unknown	<b>Expanded Ethnicity</b>
				_____
<b>Race</b> (check all that apply)	American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander		<b>Expanded Race</b>
	Asian	White		_____
	Black/African American	Unknown		

#### V. Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

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

#### VI. Facility of Diagnosis (add additional facilities in Comments)

<b>Diagnosis Type</b> (check all that apply to facility below)	HIV	Stage 3 (AIDS)	Perinatal exposure	Check if <u>SAME</u> as facility providing information
<b>Facility Name</b>				<b>*Phone</b>
				_____
<b>*Street Address</b>			<b>City</b>	
<b>County</b>		<b>State/Country</b>		<b>*ZIP Code</b>
<b>Facility Type</b>				
<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
<b>*Provider Name</b>		<b>*Provider Phone</b>	<b>Specialty</b>	

## 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 HIV+ during pregnancy	Known HIV+ after child's birth
Known to be uninfected after this child's birth	Known HIV+ sometime before birth	HIV+, time of diagnosis unknown
Known HIV+ before pregnancy	Known HIV+ at delivery	HIV status unknown

<b>Date of birthing person's first positive test result to confirm infection</b> ____/____/____	<b>Child breastfed/chestfed by birthing person</b> Yes      No      Unknown	<b>Child received premasticated/pre-chewed food from birthing person</b> Yes      No      Unknown
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### 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 <sup>1</sup>	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		M. tuberculosis, disseminated or extrapulmonary <sup>1</sup>	
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			

<sup>1</sup>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	Collection Date	Testing Option (if applicable)				
Positive	/ /	Point-of-care test by provider				
Negative	/ /	Self-test, result directly observed by a provider <sup>2</sup>				
Indeterminate		Lab test, self-collected sample				
<b>TEST</b> 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 <sup>2</sup>	
Nonreactive	Nonreactive	Nonreactive			Lab test, self-collected sample	
<b>TEST</b> 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 <sup>3</sup>	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 <sup>2</sup>	
					Lab test, self-collected sample	
<b>TEST</b> 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 <sup>4</sup>		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 <sup>2</sup>	
					Lab test, self-collected sample	
<b>TEST</b> 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 <sup>2</sup>			
Indeterminate			Lab test, self-collected sample			

<b>HIV Detection Tests</b>		<b>TEST</b>	HIV-1/2 RNA NAAT (Qualitative)	
Test Brand Name/Manufacturer		Lab Name		
Facility Name		Provider Name		
<b>Result</b> HIV-1                      HIV, not differentiated HIV-2                      (HIV-1 or HIV-2) Both (HIV-1 and HIV-2)    Neither (negative)		<b>Collection Date</b> ____/____/____		<b>Testing Option</b> (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample

  

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

  

<b>TEST</b>		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	
<b>Result</b> Positive Negative Indeterminate		<b>Collection Date</b> ____/____/____	<b>Testing Option</b> (if applicable) Point-of-care test by provider Self-test, result directly observed by a provider <sup>2</sup> Lab test, self-collected sample

  

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

  

<b>Drug Resistance Tests (Genotypic)</b>		<b>TEST</b>	HIV-1 Genotype (Unspecified)	
Test Brand Name/Manufacturer		Lab Name		
Facility Name		Provider Name		
Collection Date		____/____/____		

  

<b>Immunologic Tests (CD4 count and percentage)</b>			
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 \_\_\_\_/\_\_\_\_/\_\_\_\_

<sup>2</sup> Results not directly observed by a provider should be recorded in HIV Testing History. <sup>3</sup> Complete the overall interpretation and the analyte results. <sup>4</sup> 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
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**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	Unknown	Other (specify)
Birthing person known to be HIV-negative during pregnancy	HIV serostatus of birthing person unknown	

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

**CHECK OOS STATE:** \_\_\_\_\_

**If pregnant, list EDD (due date):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**DOC#**

**Link with e-HARS stateno(s):** \_\_\_\_\_

## XIV. \*Local/Optional Fields

**NIR Status:**

**STARS#** \_\_\_\_\_

**NIR OP Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NIR RE Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NIR CL Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hepatitis: A B C Other Unknown**

**Initials(3)** \_\_\_\_\_ **Source code:** \_\_\_\_\_