

New Jersey Department of Health and Senior Services
PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(FOR PATIENTS <13 YEARS OF AGE AT TIME OF DIAGNOSIS)

Date Received at NJDHSS

(IMPORTANT: Fields which are "shaded" are required fields and MUST be completed.)

PATIENT NAME AND ADDRESS			
Patient Name (Last, First, MI)	Alias	Telephone No.	
Address	City	State	Zip Code
County	Date Form Completed	CTS Number	Medical Record Number

NJDHSS USE ONLY		
Soundex Code	Reporting Health Department-State	State Patient Number
Surveillance Method <input type="checkbox"/> A <input type="checkbox"/> F <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> U	Reporting Health Department-City/County	
Document Source	Or Source Code A	
Did this Report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Report Medium <input type="checkbox"/> Field Visit <input type="checkbox"/> Mailed <input type="checkbox"/> Telephone <input type="checkbox"/> SDN <input type="checkbox"/> Internal Matching Program	

DEMOGRAPHIC INFORMATION			
Diagnostic Status at Report <input type="checkbox"/> Perinatally HIV Exposed <input type="checkbox"/> Confirmed HIV Infection (not AIDS)	<input type="checkbox"/> AIDS <input type="checkbox"/> Seroreverter	Date of Birth (Month/Day/Year) ___ / ___ / ___	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female
Country of Birth <input type="checkbox"/> U.S. <input type="checkbox"/> Puerto Rico <input type="checkbox"/> Other, Specify:			
Ethnicity (Select One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown	Race (Select one or more) <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pac. Isl. <input type="checkbox"/> Unknown		
Current Status <input type="checkbox"/> Alive <input type="checkbox"/> Dead	Date of Death ___ / ___ / ___	State/Territory of Death	
Date of Initial Evaluation for HIV Infection ___ / ___	Date of Last Evaluation for HIV Infection ___ / ___	Was the reason for initial HIV evaluation due to clinical signs and symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

RESIDENCE AT DIAGNOSIS			
City	County	State/Country	Zip Code _____ - _____

FACILITY OR PROVIDER PRACTICE		
Name of Facility/Provider Practice	Name of Contact Person	Main Telephone Number
Full Address of Facility/Provider Practice	City	State/Country
Name of Person Completing Form	Telephone No. of Person Completing Form	Medical Record Number
Facility Setting (Check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Unknown	Facility Type (Check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other, Specify:	

PATIENT HISTORY	
Child's biological mother's HIV Infection Status (Check one) <input type="checkbox"/> Refused HIV Testing <input type="checkbox"/> Known to be Uninfected after this child's birth <input type="checkbox"/> HIV Status Unknown	
Diagnosed with HIV infection/AIDS: <input type="checkbox"/> Before this child's pregnancy <input type="checkbox"/> At time of delivery <input type="checkbox"/> After the child's birth <input type="checkbox"/> During this child's pregnancy <input type="checkbox"/> Before child's birth, exact period unknown <input type="checkbox"/> HIV-infected, unknown when diagnosed	
Date of mother's first positive HIV confirmatory test: ___ / ___	Mother was counseled about HIV testing during this pregnancy, labor or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT (Continued)

PATIENT HISTORY, Continued

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td style="width:10%; text-align: center;">Unk</td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Mother perinatally infected</td> </tr> <tr> <td colspan="4">After 1977, this child's biologic mother had:</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Injected nonprescription drugs</td> </tr> <tr> <td colspan="4">HETEROSEXUAL relations with:</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Intravenous/injection drug user</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Bisexual male</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Male with hemophilia/coagulation disorder</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Transfusion recipient with documented HIV infection</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Transplant recipient with documented HIV infection</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Male with AIDS or documented HIV infection, risk not specified</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Received transfusion of blood/blood components (other than clotting factor)</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Received transplant of tissue/organs or artificial insemination</td> </tr> </table>	Yes	No	Unk		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother perinatally infected	After 1977, this child's biologic mother had:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injected nonprescription drugs	HETEROSEXUAL relations with:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous/injection drug user	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bisexual male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male with hemophilia/coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion recipient with documented HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplant recipient with documented HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transplant of tissue/organs or artificial insemination	<p>Before the diagnosis of HIV Infection/AIDS, this child had:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td style="width:10%; text-align: center;">Unk</td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Received clotting factor for hemophilia/coagulation disorder - specify disorder: <input type="checkbox"/>Factor VIII (Hemophilia A) <input type="checkbox"/>Factor IX (Hemophilia B) <input type="checkbox"/>Other, Specify: _____</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Received transfusion of blood/blood components (other than clotting factor) First (Mo/Yr): ___ / ___ Last (Mo/Yr): ___ / ___</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Received transplant of tissue/organs</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Sexual contact with a male</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Sexual contact with a female</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Injected nonprescription drugs</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>Other (alert State/City NIR Coordinator)</td> </tr> </table>	Yes	No	Unk		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received clotting factor for hemophilia/coagulation disorder - specify disorder: <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transfusion of blood/blood components (other than clotting factor) First (Mo/Yr): ___ / ___ Last (Mo/Yr): ___ / ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Received transplant of tissue/organs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual contact with a male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual contact with a female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injected nonprescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (alert State/City NIR Coordinator)
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LABORATORY DATA

<p>HIV Antibody Tests at Diagnosis</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">HIV-1 Western Blot</td> <td style="width:10%;"><input type="checkbox"/>Pos</td> <td style="width:10%;"><input type="checkbox"/>Neg</td> <td style="width:15%; text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>Rapid _____</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>Rapid _____</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>HIV-1 EIA</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>HIV-1/2 EIA</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>HIV-2 EIA</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>HIV-2 Western Blot</td> <td><input type="checkbox"/>Pos</td> <td><input type="checkbox"/>Neg</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> </table> <p>Positive HIV Detection Tests</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/>Culture</td> <td><input type="checkbox"/>Antigen</td> <td><input type="checkbox"/>PCR, DNA or RNA probe</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td colspan="3"><input type="checkbox"/>Other (Specify): _____</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> </table> <p>Viral Load Test (Earliest and Most Recent Tests)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Test Type</td> <td style="width:35%;">Copies/ml or Undetectable</td> <td style="width:15%; text-align: center;"><u>Earliest</u> Date</td> <td style="width:35%; text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>NASBA</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>RT-PCR</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>bDNA</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td style="text-align: center;">Test Type</td> <td style="text-align: center;">Copies/ml or Undetectable</td> <td style="text-align: center;"><u>Most Recent</u> Date</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>NASBA</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>RT-PCR</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td><input type="checkbox"/>bDNA</td> <td>_____</td> <td></td> <td style="text-align: center;">___ / ___ / ___</td> </tr> </table>	HIV-1 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	Rapid _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	Rapid _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	HIV-1 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	HIV-1/2 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	HIV-2 EIA	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	HIV-2 Western Blot	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	___ / ___ / ___	<input type="checkbox"/> Culture	<input type="checkbox"/> Antigen	<input type="checkbox"/> PCR, DNA or RNA probe	___ / ___ / ___	<input type="checkbox"/> Other (Specify): _____			___ / ___ / ___	Test Type	Copies/ml or Undetectable	<u>Earliest</u> Date	___ / ___ / ___	<input type="checkbox"/> NASBA	_____		___ / ___ / ___	<input type="checkbox"/> RT-PCR	_____		___ / ___ / ___	<input type="checkbox"/> bDNA	_____		___ / ___ / ___	Test Type	Copies/ml or Undetectable	<u>Most Recent</u> Date	___ / ___ / ___	<input type="checkbox"/> NASBA	_____		___ / ___ / ___	<input type="checkbox"/> RT-PCR	_____		___ / ___ / ___	<input type="checkbox"/> bDNA	_____		___ / ___ / ___	<p>If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify the child from the HIV/AIDS definition? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Unknown</p> <p>If HIV lab tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Unknown</p> <p>If yes, provide date of documentation by physician: ___ / ___ / ___</p> <p>Immunologic Lab Tests</p> <p>At or closest to current diagnostic status:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td>CD4 Count</td> <td style="text-align: center;">___ cells/∞L</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>CD4 Percent</td> <td style="text-align: center;">___ %</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>First <200 ∞L or 14%</td> <td></td> <td></td> </tr> <tr> <td>CD4 Count</td> <td style="text-align: center;">___ cells/∞L</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> <tr> <td>CD4 Percent</td> <td style="text-align: center;">___ %</td> <td style="text-align: center;">___ / ___ / ___</td> </tr> </table> <p>Genotype Testing</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Lab: _____ Date: ___ / ___ / ___</p>	CD4 Count	___ cells/∞L	___ / ___ / ___	CD4 Percent	___ %	___ / ___ / ___	First <200 ∞L or 14%			CD4 Count	___ cells/∞L	___ / ___ / ___	CD4 Percent	___ %	___ / ___ / ___
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AIDS INDICATOR DISEASES

AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)	AIDS Indicator Disease	Initial Diag.		Initial Date (Month/Year)
	Def.*	Pres.*			Def.*	Pres.*	
Bacterial infections, multiple or recurrent (including Salmonella septicemia)		N/A	___ / ___	Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia			___ / ___
Candidiasis, bronchi, trachea, or lungs		N/A	___ / ___	Lymphoma, Burkitt's (or equivalent term)		N/A	___ / ___
Candidiasis, esophageal			___ / ___	Lymphoma, immunoblastic (or equivalent term)		N/A	___ / ___
Coccidioidomycosis, disseminated or extrapulmonary		N/A	___ / ___	Lymphoma, primary in brain		N/A	___ / ___
Cryptococcosis, extrapulmonary		N/A	___ / ___	<i>Mycobacterium avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary			___ / ___
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		N/A	___ / ___	<i>M. tuberculosis</i> , pulmonary **			___ / ___
Cytomegalovirus disease (other than in liver, spleen, or nodes)		N/A	___ / ___	<i>M. tuberculosis</i> , disseminated or extrapulmonary **			___ / ___
Cytomegalovirus retinitis (with loss of vision)		N/A	___ / ___	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary			___ / ___
HIV encephalopathy		N/A	___ / ___	<i>Pneumocystis carinii</i> pneumonia			___ / ___
Herpes simplex: chronic ulcer(s) (>1 mo. duration), or bronchitis, pneumonitis or esophagitis onset at >1 month of age		N/A	___ / ___	Progressive multifocal leukoencephalopathy		N/A	___ / ___
Histoplasmosis, disseminated or extrapulmonary		N/A	___ / ___	Toxoplasmosis of brain			___ / ___
Isosporiasis, chronic intestinal (>1 mo. duration)		N/A	___ / ___	Wasting syndrome due to HIV		N/A	___ / ___
Kaposi's sarcoma			___ / ___	Has this child been diagnosed with pulmonary tuberculosis?			___ / ___
* Def. = Definitive Diagnosis Pres. = Presumptive Diagnosis				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT (Continued)

BIRTH HISTORY (for PERINATAL cases only)			
Birth history was available for this child: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If No or Unknown, proceed to Treatment/Services Referrals.</i>			
Hospital at Birth			
Hospital Name		City	State/Country
Residence at Birth			
City	County	State/Country	Zip Code
Birthweight (enter lbs./oz. OR grams) _ _ lbs. / _ _ oz. OR _ _ _ grams		Birth Type <input type="checkbox"/> Single <input type="checkbox"/> Twin <input type="checkbox"/> >2 <input type="checkbox"/> Unknown	
Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Elective Caesarean <input type="checkbox"/> Non-elective Caesarean <input type="checkbox"/> Caesarean, unknown type <input type="checkbox"/> Unknown			
Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify Type(s): _____ Code: _ _ _ . _ _ _			
Neonatal Status <input type="checkbox"/> Full Term <input type="checkbox"/> Premature Weeks: _ _ 99 = Unknown		Month of pregnancy prenatal care began: Month: _ _ 99 = Unknown 00 = None	Total number of prenatal care visits: _ _ 99 = Unknown 00 = None
Did mother receive zidovudine (ZDV, AZT) during pregnancy? <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did mother receive zidovudine (ZDV, AZT) during labor/delivery? <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did mother receive any other Anti-retroviral medication during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify: _____	
If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? _ _ Weeks 99 = Unknown	Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did mother receive any other Anti-retroviral medication during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify: _____	
MATERNAL DATA			
Maternal Date of Birth: ___/___/___	Maternal Soundex: _ _ _	Mother's Name: _____	Maternal State Patient No.: _____
Birthplace of Biologic Mother: <input type="checkbox"/> U.S. <input type="checkbox"/> U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			
TREATMENT/SERVICES REFERRALS			
This child received or is receiving:			Date Started
Neonatal zidovudine (ZDV, AZT) for HIV <i>prevention</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown.....			___/___/___
Other neonatal anti-retroviral medication for HIV <i>prevention</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown.....			___/___/___
If yes, specify: _____			
Anti-retroviral therapy for HIV <i>treatment</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown.....			___/___/___
PCP prophylaxis..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown.....			___/___/___
Was child breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
This child has been enrolled at (clinical trial)? <input type="checkbox"/> NIH Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown		This child has been enrolled at (clinic)? <input type="checkbox"/> HRSA Sponsored <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown	
This child's medical treatment is primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance/HMO <input type="checkbox"/> No Coverage <input type="checkbox"/> Other Public Funding <input type="checkbox"/> Clinical Trial/Government Program <input type="checkbox"/> Unknown			
This child's primary caretaker is: <input type="checkbox"/> Biologic parent(s) <input type="checkbox"/> Other relative <input type="checkbox"/> Foster/Adoptive parent, relative <input type="checkbox"/> Foster/Adoptive parent, unrelated <input type="checkbox"/> Social service agency <input type="checkbox"/> Other (specify in "Comments") <input type="checkbox"/> Unknown			
	State Number	Date of Birth	Name
Father:	_____	___/___/___	_____
Siblings:	_____	___/___/___	_____
	_____	___/___/___	_____
	_____	___/___/___	_____
	_____	___/___/___	_____
	_____	___/___/___	_____

