

## Reporting HIV and AIDS in Iowa

**What's reportable** AIDS has been a reportable disease in Iowa since February 1983. HIV became reportable by name in Iowa on July 1, 1998. **Iowa Administrative Code 641.11.6.**, below, details reporting.

### **641—11.6(141A) Reporting of diagnoses and HIV-related tests, events, and conditions to the department.**

**11.6(1)** The following constitute reportable events related to HIV infection:

*a.* A test result indicating HIV infection, including:

(1) Confirmed positive results on any HIV-related test or combination of tests, including antibody tests, antigen tests, cultures, and nucleic acid amplification tests.

(2) A positive result or report of a detectable quantity on any other HIV detection (non-antibody) tests, and results of all viral loads, including nondetectable levels.

*b.* AIDS and AIDS-related conditions, including all levels of CD4+ T-lymphocyte counts.

*c.* Birth of an infant to an HIV-infected mother (perinatal exposure) or any (positive, negative, or undetectable) non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger.

*d.* Death resulting from an AIDS-related condition, or death of a person with HIV infection.

**11.6(2)** Within seven days of the receipt of a person's confirmed positive test result indicating HIV infection, the director of a plasma center, blood bank, clinical laboratory or public health laboratory that performed the test or that requested the confirmatory test shall make a report to the department on a form provided by the department.

**11.6(3)** Within seven days of the receipt of a test result indicating HIV infection, which has been confirmed as positive according to prevailing medical technology, or immediately after the initial examination or treatment of a person infected with HIV, the physician or other health care provider at whose request the test was performed or who performed the initial examination or treatment shall make a report to the department on a form provided by the department.

**11.6(4)** Within seven days of diagnosing a person as having AIDS or an AIDS-related condition, the diagnosing physician shall make a report to the department on a form provided by the department.

**11.6(5)** Within seven days of the death of a person with HIV infection, the attending physician shall make a report to the department on a form provided by the department.

**11.6(6)** Within seven days of the birth of an infant to an HIV-infected mother or a receipt of a laboratory result (positive, negative, or undetectable) of a non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger, the attending physician shall make a report to the department on a form provided by the department.

**11.6(7)** The report shall include:

*a.* The person's name, address, date of birth, gender, race and ethnicity, marital status, and telephone number.

*b.* The name, address and telephone number of the plasma center, blood bank, clinical laboratory or public health laboratory that performed or requested the test, if a test was performed.

*c.* The address of the physician or other health care provider who requested the test.

*d.* If the person is female, whether the person is pregnant.

**11.6(8)** All persons who experience a reportable event while receiving services in the state, regardless of state of residence, shall be reported.

**Need reporting forms? Want to call in a report? Have questions? Need surveillance data?**

Alagie "Al" Jatta, HIV Surveillance Coordinator: 515-242-5141 [Alagie.Jatta@idph.iowa.gov](mailto:Alagie.Jatta@idph.iowa.gov),  
Jessica Morris, HIV Surveillance Epidemiologist: 515-281-6918 [Samoane.Don@idph.iowa.gov](mailto:Samoane.Don@idph.iowa.gov) ;

**For free postpaid "03 CONFIDENTIAL" envelopes, call the Clearinghouse at 1-888-398-9696**

**COMPLETED FORMS MAY BE SENT VIA THE U.S. POSTAL SERVICE OR YOU CAN USE THE FORM TO COLLECT THE REQUIRED DATA AND THEN CALL US. FAXING OR EMAILING OF COMPLETED FORMS IS NOT ALLOWED!**

**By Mail:**

Iowa Department of Public Health  
321 East 12th Street  
Des Moines, IA 50319  
"03 Confidential"

**By Phone:**

Alagie Jatta at 515-281-6918

## **INSTRUCTIONS**

**Don't panic.** The form can seem a little foreboding. We do not expect you to know everything on the form, but we do expect you to provide all of the requested information that is known to you.

**Additional information.** The form is the standard CDC report form. It asks for standard CDC information. In addition to the standard information, please use the comment sections of the form to provide any information you may have on the following:

- Mother's living situation (Who knows about her HIV status? Who doesn't?)
- Mother's marital or relationship status (including HIV status of partners)
- Maintaining patient confidentiality is supremely important. With this in mind, what is the best way (e.g., a specific phone telephone number, time or place) for a trained Disease Prevention Specialist to contact the mother to provide education about HIV, link her to available resources for her and the infant, and offer other assistance as appropriate?
- Other places, either in Iowa or out-of-state, the mother may have lived?
- Mother's Social Security Number

**Questions?** Please call 515-281-6918.

**Thank you!** Thank you for complying with Iowa's HIV reporting statutes!

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

*First Name		*Middle Name		*Last Name		Last Name Soundex			
Alternate Name Type (ex: 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"/> 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				*Number	

U.S. Department of Health  
& Human Services**Pediatric HIV Confidential Case Report Form**  
(Patients <13 Years of Age at Time of Diagnosis) \* Information NOT transmitted to CDCCenters for Disease Control  
and Prevention**Health Department Use Only (record all dates as mm/dd/yyyy)**

Form approved OMB no. 0920-0573 Exp. 06/30/2019

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 <input type="checkbox"/> Other, specify _____		<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Other, specify _____		<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <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 Type (Check all that apply to address below) <input type="checkbox"/> Residence at HIV diagnosis <input type="checkbox"/> Residence at AIDS diagnosis <input type="checkbox"/> Residence at Perinatal Exposure <input type="checkbox"/> Residence at Pediatric Seroreverter <input type="checkbox"/> Check if <u>SAME as Current Address</u>							
* Street Address						Address Date ____/____/____	
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.**

**STATE/LOCAL USE ONLY**

\*Provider Name (Last, First, M.I.) \_\_\_\_\_

\*Phone ( ) \_\_\_\_\_

Hospital/Facility \_\_\_\_\_

**Facility of Diagnosis (add additional facilities in Comments)**

<b>Diagnosis Type</b> (Check all that apply to facility below) <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Perinatal Exposure <input type="checkbox"/> 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> <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____		<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Pediatric Clinic <input type="checkbox"/> Pediatric HIV Clinic <input type="checkbox"/> Other, specify _____	
<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____			
<b>*Provider Name</b> _____		<b>*Provider Phone</b> ( ) _____	<b>Specialty</b> _____

**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 HIV confirmatory test: ___/___/____	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
<b>After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:</b>	
Perinatally acquired HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Biological Mother had HETEROSEXUAL relations with any of the following:</b>	
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
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
<b>Before the diagnosis of HIV infection, this child had:</b>	
Injected non-prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	Specify clotting factor: _____ Date received: ___/___/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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

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

<b>HIV Immunoassays (Non-differentiating)</b>			
<b>TEST 1:</b> <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: _____			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<b>TEST 2:</b> <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: _____			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<b>HIV Immunoassays (Differentiating)</b>			
<input type="checkbox"/> HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT:</b> <input type="checkbox"/> Ag reactive <input type="checkbox"/> Ab reactive <input type="checkbox"/> Both (Ag and Ab reactive) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Invalid/Indeterminate		<b>Collection Date:</b> ___/___/___ <input type="checkbox"/> Rapid Test (check if rapid)	
<input type="checkbox"/> HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)			
Test Brand Name/Manufacturer: _____			
<b>RESULT*: HIV-1 Ag</b>		<b>HIV-Ab</b>	
<input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive <input type="checkbox"/> Not Reported		<input type="checkbox"/> HIV-1 Reactive <input type="checkbox"/> HIV-2 Reactive <input type="checkbox"/> Both Reactive, Undifferentiated <input type="checkbox"/> Both Nonreactive	
<b>Collection Date:</b> ___/___/___		*Select one result for HIV-1 Ag and one result for HIV Ab	
<b>HIV Detection Tests (Qualitative)</b>			
<b>TEST:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture			
<b>RESULT:</b> <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate		<b>Collection Date:</b> ___/___/___	
<b>HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis</b>			
<b>TEST 1:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
<b>RESULT:</b> <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		<b>Copies/mL:</b> _____	<b>Log:</b> _____ <b>Collection Date:</b> ___/___/___
<b>TEST 2:</b> <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Quantitative viral load)			
<b>RESULT:</b> <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		<b>Copies/mL:</b> _____	<b>Log:</b> _____ <b>Collection Date:</b> ___/___/___
<b>Immunologic Tests (CD4 count and percentage)</b>			
<b>CD4 at or closest to diagnosis: CD4 count:</b> _____ cells/ $\mu$ L <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/___			
<b>First CD4 result &lt;200 cells/<math>\mu</math>L or &lt;14%: CD4 count:</b> _____ cells/ $\mu$ L <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/___			
<b>Other CD4 result: CD4 count:</b> _____ cells/ $\mu$ L <b>CD4 percentage:</b> ___% <b>Collection Date:</b> ___/___/___			
<b>Documentation of Tests</b>			
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 was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]			
If laboratory tests were not documented,		<b>HIV-Infected</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date of diagnosis:</b> ___/___/___
is patient confirmed by a physician as:		<b>Not HIV-Infected</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date of diagnosis:</b> ___/___/___

**Clinical (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*	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary*	
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 hyperplasia		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	

\*If TB selected above, indicate RVCT Case Number:

**Birth History (for Perinatal Cases only)**

<b>Residence at Birth</b>			
Birth History Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Check if SAME as Current Address	
* Street Address		City	
County	State/Country	*ZIP Code	
<b>Facility of Birth</b>			
<input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name of Birth (if child was born at home, enter "home birth")		*Phone (    ) _____	*ZIP Code
Facility Type	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <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
<b>Birth History</b>			
Birth Weight _____ lbs _____ oz _____ grams	Type <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3->2 <input type="checkbox"/> 9-Unknown	Delivery <input type="checkbox"/> 1-Vaginal <input type="checkbox"/> 2-Elective Cesarean <input type="checkbox"/> 3-Non-Elective 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, please specify:		
Neonatal Status <input type="checkbox"/> 1-Full-term <input type="checkbox"/> 2-Premature <input type="checkbox"/> Unknown	Neonatal Gestational Age in Weeks: _____ (99-Unknown)		
Gestational Month Prenatal Care Began (00-None, 99-Unknown)	Prenatal Care – Total number of prenatal care visits: (00-None, 99-Unknown)		
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	If yes, please specify all:		
Did mother receive any ARVs during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please specify all:		
Did mother receive any ARVs during labor/delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please specify all:		
<b>Maternal Information</b>			
Maternal DOB	Maternal Last Name Soundex	Maternal Stateno	Maternal Country of Birth
*Other Maternal ID – List Type		Number	

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

<b>This child received or is receiving:</b>			
Neonatal ARVs for HIV prevention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date began: ___/___/_____	Date of last use: ___/___/_____	
If Yes, please specify: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____			
Anti-retroviral therapy for HIV treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date began: ___/___/_____	Date of last use: ___/___/_____	
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**


**\*Local/Optional Fields**


This report to the Centers for Disease Control and Prevention (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).

# Perinatal HIV Exposure Reporting (PHER)

Infant's State Number \_\_\_\_\_  
Infant's City Number \_\_\_\_\_

Mother's State Number \_\_\_\_\_  
Mother's City Number \_\_\_\_\_

Form Approved OMB No. 0920-0573 Exp. Date 06/30/2019

**1. If information on the mother is not available, was the child adopted, or in foster care?**

Yes  No  Not applicable

**2. Records abstracted**

(1 = Abstracted, 2 = Attempted—record not available, 3 = Not abstracted, 4 = Attempted—will try again)

____ Prenatal care records	____ Pediatric medical records (non-HIV clinic or provider)
____ Maternal HIV clinic records	____ Birth certificate
____ Labor and delivery records	____ Death certificate
____ Pediatric birth records	____ Health department records
____ Pediatric HIV medical records	____ Other (Specify) _____

**3. Weeks' gestation at first prenatal care visit**

\_\_\_\_ weeks

**4. Was the mother screened for any of the following during pregnancy?**

(Check test(s) performed before birth, but closest to date of delivery or admission to labor and delivery)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Group B strep	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (HBsAg)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Diagnosis (for the mother) of the following conditions during this pregnancy or at the time of labor and delivery**

(See instructions for data abstraction for definitions)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Bacterial vaginosis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia trachomatis infection	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital herpes	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group B strep	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (HbsAg+)	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PID	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trichomoniasis	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. Mother's reproductive history**

\_\_\_\_ No. of previous pregnancies      \_\_\_\_ No. of previous miscarriages or stillbirths  
 \_\_\_\_ No. of previous live births      \_\_\_\_ No. of previous induced abortions OR \_\_\_\_ Total No. of previous abortions

**7. Complete the chart for all siblings.**

	Date of birth (mm/dd/yyyy)	Age (yrs: mos as of mm/yyyy)	HIV serostatus (See list below)	State Number	City Number
Sib 1	____/____/____	__:__ as of ____/____/____	_____	_____	_____
Sib 2	____/____/____	__:__ as of ____/____/____	_____	_____	_____
Sib 3	____/____/____	__:__ as of ____/____/____	_____	_____	_____
Sib 4	____/____/____	__:__ as of ____/____/____	_____	_____	_____

HIV serostatus: 1 = Infected, 2 = Not infected, 3 = Indeterminate, 9 = Not documented, U = Unknown

**8. Was substance use during pregnancy noted in the medical or social work records?**

- Yes  No (Go to 9)  Record not available (Go to 9)  Unknown

**8a. If yes, indicate which substances were used during pregnancy. (Check all that apply)**

- Alcohol  Cocaine  Marijuana (cannabis, THC, cannabinoids)  Opiates  
 Amphetamines  Crack cocaine  Methadone  Other (Specify) \_\_\_\_\_  
 Barbiturates  Hallucinogens  Methamphetamines  Specific drug(s) not documented  
 Benzodiazepines  Heroin  Nicotine (any tobacco product)

**8b. If substances used, were any injected?**

- Yes  No  Not documented  Unknown  Specify injected substance(s). \_\_\_\_\_

**9. Was a toxicology screen done on the mother (either during pregnancy or at the time of delivery)?**

- Yes, positive result (Check all that apply)

- Alcohol  Cocaine  Marijuana (cannabis, THC, cannabinoids)  Opiates  
 Amphetamines  Crack cocaine  Methadone  Other (Specify) \_\_\_\_\_  
 Barbiturates  Hallucinogens  Methamphetamines  Specific drug(s) not documented  
 Benzodiazepines  Heroin  Nicotine (any tobacco product)

- Yes, negative result  
 No  
 Toxicology screen not documented

**10. Was a toxicology screen done on the infant at birth?**

- Yes, positive result (Check all that apply)

- Alcohol  Cocaine  Marijuana (cannabis, THC, cannabinoids)  Opiates  
 Amphetamines  Crack cocaine  Methadone  Other (Specify) \_\_\_\_\_  
 Barbiturates  Hallucinogens  Methamphetamines  Specific drug(s) not documented  
 Benzodiazepines  Heroin  Nicotine (any tobacco product)

- Yes, negative result  
 No  
 Toxicology screen not documented

**11. Was the mother's HIV serostatus noted in her prenatal care medical records?**

- Yes, HIV-positive  Yes, HIV-negative  No  No prenatal care  Record not available  Unknown

**12. Were antiretroviral drugs prescribed for the mother during this pregnancy?**

- Yes (Complete table)  No (Go to 12a)  Not documented (Go to 13)  Record not available (Go to 13)  Unknown (Go to 13)

	Drug name	Drug refused	Date drug started (mm/dd/yyyy)	Gestational age drug started (weeks; round down)	Drug stopped			Date stopped (if yes in preceding column) (mm/dd/yyyy)	Stop codes (See list on p. 4)
					Yes	No	ND		
i.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
ii.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iii.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iv.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
v.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
vi.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

(After completing table, go to 13)

**12a. If no antiretroviral drug was prescribed during pregnancy, check reason.**

- No prenatal care  Mother known to be HIV-negative during pregnancy  Not documented  Unknown  
 HIV serostatus of mother unknown  Mother refused  Other (Specify) \_\_\_\_\_

**13. Was mother's HIV serostatus noted in her labor and delivery records?**

- Yes, HIV-positive  Yes, HIV-negative  No  Record not available  Unknown



**14. Did mother receive antiretroviral drugs during labor and delivery?**

- Yes (Complete table)  
  No (Go to 14a)  
  Not documented (Go to 15)  
  Record not available (Go to 15)  
  Unknown (Go to 15)

	Drug name	Drug refused	Date received (mm/dd/yyyy)	Time received (See military time)	Type of administration		
					Oral	IV	Not documented
i.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(After completing the table, go to 15)

Military time: noon = 12:00; midnight = 00:00

**14a. If no antiretroviral drug was received during labor and delivery, check reason.**

- Precipitous delivery/STAT Cesarean delivery  
  HIV serostatus of mother unknown  
  Mother tested HIV-negative during pregnancy  
  Other (Specify) \_\_\_\_\_  
 Prescribed but not administered  
  Birth not in hospital  
 Mother refused  
 Not documented  
 Unknown

**15. Was mother referred for HIV care after delivery?**

- Yes  
  No (Go to 17)  
  Not documented (Go to 17)  
  Record not available (Go to 17)  
  Unknown

**16. If yes, indicate mother's first CD4 result or first viral load result after discharge from hospital (up to 6 months after discharge).**

16a. CD4 result			16b. Viral load result		
Result	Unit	Date blood drawn (mm/dd/yyyy)	Result in copies/mL	Result in logs	Date blood drawn (mm/dd/yyyy)
-----	cells/μL	___/___/___	_____	_____	___/___/___
---	%	___/___/___			

**17. Birth information**

- Birth not in hospital  
  Record not available

	Time (See military time)	Date (mm/dd/yyyy)		Time (See military time)	Date (mm/dd/yyyy)
Onset of labor	___:___	___/___/___	Rupture of membranes	___:___	___/___/___
Admission to labor and delivery	___:___	___/___/___	Delivery	___:___	___/___/___

Military time: noon = 12:00; midnight = 00:00

**18. If Cesarean delivery, mark all the following indications that apply.**

- HIV indication (high viral load)  
  Mother's or physician's preference  
  Other (e.g., herpes, disproportion) (Specify) \_\_\_\_\_  
 Previous Cesarean (repeat)  
  Fetal distress  
 Not specified  
 Malpresentation (breech, transverse)  
  Placenta abruptia or p. previa  
 Not applicable  
 Prolonged labor or failure to progress

**19. Was mother's HIV serostatus noted on the child's birth record?**

- No  
  Yes, HIV-positive  
  Yes, HIV-negative  
  Record not available  
  Unknown

**20. Were antiretroviral drugs prescribed for the child?**

Yes (Complete table)     No (Go to 20a)     Not documented     Record not available     Unknown

Drug name	Drug refused	Date drug started (mm/dd/yyyy)	Time started (See military time)	Drug stopped				Stop date (if therapy not completed) (mm/dd/yyyy)	Stop codes (See list)
				Yes	No	ND	UNK		
i. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
ii. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iii. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iv. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
v. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
vi. _____	<input type="checkbox"/>	___/___/___	__:__:__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

Military time: noon = 12:00; midnight = 00:00

**20a. If no antiretroviral drug was prescribed, indicate reason.**

- HIV serostatus of mother unknown                       Other (Specify) \_\_\_\_\_  
 Mother known to be HIV-negative during pregnancy     Not documented  
 Mother refused

**Stop codes (2 codes allowed; if more, choose the 2 most important)**

- |   |  |
|---|--|
| <b>S1</b> = Adverse events (toxicity, lack of tolerance)            | <b>S9</b> = Pregnancy                                |
| <b>S2</b> = ART completed   | <b>S10</b> = Child determined not to be HIV infected |
| <b>S3</b> = Drug resistance detected                                | <b>S11</b> = Improving effectiveness                 |
| <b>S4</b> = Poor adherence  | <b>S12</b> = Improving convenience                   |
| <b>S5</b> = Inadequate effectiveness                                | <b>S13</b> = Reason not indicated; unknown           |
| <b>S6</b> = Strategic treatment interruption (planned drug holiday) | <b>S14</b> = Mother couldn't afford drugs            |
| <b>S7</b> = Drug interactions                                       | <b>Sxx</b> = Other reason                            |
| <b>S8</b> = Mother's choice   |  |

**List of abbreviations**

ART	antiretroviral therapy
ND	not documented
PCP	<i>Pneumocystis jirovecii</i> pneumonia [ <i>jirovecii</i> is now preferred to <i>carinii</i> ; abbreviation is the same]
PID	pelvic inflammatory disease
STAT	immediately ( <i>statim</i> )

**Comments**

Please include comments or clinical information you consider relevant to the overall understanding of this child's HIV exposure or infection status. State the date and source of the information.