HIV-Exposed Infants And Pediatric Cases - Case Investigatio

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CASE INVESTIGATION REPORT

HIV-Exposed Infants and Paediatric Cases (Age Less Than 12 Years)

CONTACT TRACING	◯ Trace	◯ Do not trace

REASON FOR SUBMITTING CONFIDENTIAL REPORTING FORM		
◯ HIV-Exposed	◯ AIDS Diagnosis	◯ ART Initiation
◯ Initial HIV Diagnosis	◯ Death Notification	◯ Viral suppression
◯ Advanced HIV Diagnosis	◯ Treatment Regimen Change	◯ Risk History Update

INFANT'S/CHILD'S DEMOGRAPHICS	
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Country of Residence:	Parish (Jamaica):
House Number, Street Name, Community:	
Landmark or directions to address:	
Phone Number:	Email Address:
Sex Assigned at Birth: ◯ Male ◯ Female	**Infant's/Child's Medical Record Number:**
Date of Birth: *DD/MM/YYYY*	

RISK FACTORS			
Date of Assessment: *DD/MM/YYYY*	**Yes**	**No**	**Unknown**
◯ Infant born to HIV positive mother	◯	◯	◯
◯ Breastfeeding	◯	◯	◯
◯ Mother had High Viral Load in Pregnancy	◯	◯	◯
◯ Late HIV Diagnosis in Pregnant Mother	◯	◯	◯
◯ Non-Adherence to ART by Mother	◯	◯	◯
◯ Sexual Contact of Child	◯	◯	◯
◯ Lost to Follow-up Child	◯	◯	◯
◯ Lost to Follow-up Mother	◯	◯	◯
◯ Non-Disclosure of HIV Status by Mother to Partner/Relative	◯	◯	◯
◯ Vaginal Delivery	◯	◯	◯
◯ Infant/Child Received Transfusion of Blood Products	◯	◯	◯
◯ Other (specify):	◯	◯	◯

Nutrition:	◯ Exclusively Breastfed	◯ Replacement Feed Only	◯ Both Breastfed and Replacement Fed

CLINICAL STATUS (DIAGNOSIS BY PHYSICIAN)			
Date of Assessment: *DD/MM/YYYY*	**Yes**	**No**	**Unknown**
◯ Asymptomatic	◯	◯	◯
◯ Generalised lymphadenopathy	◯	◯	◯
◯ Generalised dermatitis	◯	◯	◯
◯ Unexplained persistent parotid enlargement	◯	◯	◯
◯ Hepatosplenomegaly	◯	◯	◯
◯ Recurrent diarrhoea	◯	◯	◯
◯ Recurrent/chronic upper respiratory tract infections	◯	◯	◯

CLINICAL STATUS (DIAGNOSIS BY PHYSICIAN)			
Date of Assessment: *DD/MM/YYYY*	Yes	No	Unknown
◯ Pulmonary tuberculosis	◯	◯	◯
◯ Failure to thrive	◯	◯	◯
◯ Multiple or recurrent bacterial infections	◯	◯	◯
◯ Neurological involvement	◯	◯	◯
◯ Oesophageal candidiasis	◯	◯	◯
◯ Recurrent lower respiratory tract infections	◯	◯	◯
◯ Cytomegalovirus retinitis	◯	◯	◯
◯ Extrapulmonary tuberculosis	◯	◯	◯
◯ Other (specify):	◯	◯	◯

Clinical Notes:

ANTIRETROVIRAL THERAPY (INFANT/CHILD)

ARV	Dosage	Actual Duration Received (weeks)	Comments
◯ Nevirapine			
◯ Zidovudine			
◯ Lamivudine			
◯ Abacavir			
◯ Lopinavir/Ritonavir			
◯ Dolutegravir			
◯ Tenofovir			
◯ Other (specify):			

Current Status of Patient:

◯ Pending	◯ Advanced HIV	◯ AIDS	◯ AIDS Death
◯ HIV	◯ HIV Negative		

Date of Onset of Symptoms: *DD/MM/YYYY*	Date diagnosed as Advanced HIV: *DD/MM/YYYY*
Date diagnosed as AIDS: *DD/MM/YYYY*	Date of death: *DD/MM/YYYY*

Cause of death:

ii.	iii.	iiii.
(immediate cause)	(intermediate cause)	(underlying cause)

MOTHER'S INFORMATION

Mother's ID Type: ◯ Driver's License ◯ TRN ◯ Passport Number ◯ NIDS	Mother's ID Number:
Mother's First Name:	Mother's Middle Name(s):
Mother's Last Name:	Mother's Pet Name(s):
Mother's Maiden Name (if applicable):	
Mother's Date of Birth: *DD/MM/YYYY*	Mother's Age:
Mother's Country of Residence:	Parish (Jamaica):
House Number, Street Name, Community:	

Landmark or directions to address:

Phone Number:	Email Address:
Mother's Medical Record Number:	Treatment Site:
HIV Status of Mother: ◯ Positive ◯ Negative	Date of Mother's Confirmatory HIV Test: *DD/MM/YYYY*

Laboratory where Mother's Confirmatory HIV Test Performed:

◯ National Public Health Laboratory	◯ University Hospital of the West Indies	◯ Other Government Laboratory Facility	◯ Other

Site of Delivery:

◯ Public Hospital	◯ Private Doctor	◯ Health Centre	◯ **Other (Specify):**
◯ Private Hospital	◯ Private Obstetrician	◯ Home	

Gravida:	Parity:

Treatment During Pregnancy

Antenatal ARV Treatment	**ART Start Date (*DD/MM/YYYY*)**	**Antenatal ARV Treatment**	**ART Start Date (*DD/MM/YYYY*)**
◯ Tenofovir/Lamivudine		◯ Atazanavir/Ritonavir	
◯ Tenofovir/Emtricitabine		◯ Darunavir/Ritonavir	
◯ Abacavir/Lamivudine		◯ Zidovudine/Lamivudine	
◯ Dolutegravir		◯ Nevirapine	
◯ Lopinavir/Ritonavir		◯ Other (specify):	

Antenatal Care (this pregnancy):

◯ Public Hospital	◯ Private Doctor	◯ Health Centre
◯ Private Hospital	◯ Private Obstetrician	◯ None

Mother's Next of Kin

First Name:	Last Name:
Phone number:	Email address:

Address: Lot/ Street/Community/Parish:

Relationship to the Mother:

◯ Husband	◯ Daughter	◯ Brother	◯ Aunt	◯ Friend
◯ Mother	◯ Son	◯ Grandmother	◯ Uncle	◯ Other
◯ Father	◯ Sister	◯ Grandfather	◯ Cousin	

FATHER'S INFORMATION

Father's First Name:	Father's Middle Name(s):
Father's Last Name:	Father's Pet Name(s):
Father's Date of Birth: *DD/MM/YYYY*	Father's Age:
HIV Status of Father ◯ Positive ◯ Negative	Date of Father's Confirmatory HIV Test: *DD/MM/YYYY*

Laboratory where Father's Confirmatory HIV Test Performed:

◯ National Public Health Laboratory	◯ University Hospital of the West Indies	◯ Other Government Laboratory Facility	◯ Other

SAMPLE AND LAB INFORMATION

HIV Testing for Infant/Child	Date (DD/MM/YYYY)	Result	Comment
◯ PCR at birth	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ 2-Week PCR (if high risk)	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ 6-Week PCR	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ 4-Month PCR	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ 18-Month ELISA	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ Determine Rapid Antibody	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ Uni-Gold Rapid Antibody	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
◯ Other_____	DD/MM/YYYY	◯ Positive ◯ Negative ◯ Indeterminate	
Comments:			

Notifier's Details		
Date of Reporting *{DD/MM/YYYY}*:		
First Name:	Last Name	
Professional Group:		
Phone number:	Email Address:	
Name of Institution:		
Parish:	Community:	
Office Number/Street Name:		
Health Region: ◯ SERHA ◯ NERHA ◯ SRHA ◯ WRHA		
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*

Name of Patient:---------- **Medical Record Number:----------**

Definitions (Diagnosis by physician)

Asymptomatic	No symptoms or signs suggestive of HIV infection.
Hepatosplenomegaly	Enlargement of liver and/or spleen.
Generalised Lymphadenopathy	Enlargement of more than 1 cm of more than 2 noncontiguous lymph node groups. Common sites are head, neck, post- or pre- auricular, supraclavicular, axillary, epitrochlear, and inguinal.
Cytomegalovirus retinitis	Commonly asymptomatic; fundoscopy usually reveals bilateral changes, often affecting the macula ranging from white flecks giving a granular appearance to more fulminant disease affecting the full thickness of the retina with retinal oedema, retinal vascular sheathing, or haemorrhages. CMV can also affect other organ systems.
Extrapulmonary tuberculosis	Systemic illness that may include prolonged fever, night sweats, weight loss; presentation dependent on organ system involved; culture, microscopy or other laboratory evidence of Mycobacterium tuberculosis in specimen.
Failure to thrive	Weight for age and sex below 3rd to 5th percentile; loss of weight associated with crossing two or more percentiles on a standardised growth curve; weight for height z-score below minus 2 (-2}.
Generalised dermatitis	Unexplained rash to multiple parts of the body.
Recurrent diarrhoea	Three (3} or more watery stools in a 24-hour period, recurring on two or more days during a 14-day period.
Unexplained persistent parotid enlargement	Unexplained enlargement of the parotid glands, usually bilateral and painless.
Recurrent/chronic upper respiratory tract infections	Two or more episodes of upper respiratory tract infection such as ear, nose, throat, sinuses within a six-month period.
Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	Candidiasis of the mouth in infants above 3 months of age; may be associated with decreased feeding or crying during feeding.
Neurological involvement	Unexplained recent onset of seizures, toxoplasmosis, cytomegalovirus (CMV}, cryptococcus, encephalopathy. Delayed development and/or loss of developmental milestones.
Recurrent lower respiratory tract infections	Two or more episodes of lower respiratory tract infections within a 6-month period presenting with respiratory distress or positive findings on examination e.g., crackles, consolidation; and/or positive findings on imaging or laboratory investigation.
Multiple or recurrent bacterial infections	Two or more episodes of bacterial infection requiring hospitalisation within a 6-month period.
Pulmonary tuberculosis	Symptoms of chronic cough, fever, night sweats, weight loss; abnormal findings on imaging e.g., chest X-ray and/or demonstration of the Mycobacterium tuberculosis pathogen by microscopy, culture or molecular (e.g., polymerase chain reaction} methods.

Name of Patient:---------- **Medical Record Number:----------**