

CASE INVESTIGATION REPORT

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

REASON FOR SUBMITTING CONFIDENTIAL REPORTING FORM

<input type="checkbox"/> HIV-Exposed	<input type="checkbox"/> AIDS Diagnosis	<input type="checkbox"/> ART Initiation
<input type="checkbox"/> Initial HIV Diagnosis	<input type="checkbox"/> Death Notification	<input type="checkbox"/> Viral suppression
<input type="checkbox"/> Advanced HIV Diagnosis	<input type="checkbox"/> Treatment Regimen Change	<input type="checkbox"/> 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
<input type="checkbox"/> Infant born to HIV positive mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mother had High Viral Load in Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Late HIV Diagnosis in Pregnant Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Non-Adherence to ART by Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sexual Contact of Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lost to Follow-up Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lost to Follow-up Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Non-Disclosure of HIV Status by Mother to Partner/Relative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vaginal Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infant/Child Received Transfusion of Blood Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nutrition:

<input type="checkbox"/> Exclusively Breastfed	<input type="checkbox"/> Replacement Feed Only	<input type="checkbox"/> Both Breastfed and Replacement Fed
--	--	---

Contact Tracing:

<input type="checkbox"/> Trace	<input type="checkbox"/> Do not trace
--------------------------------	---------------------------------------

CLINICAL STATUS (DIAGNOSIS BY PHYSICIAN)

Date of Assessment: DD/MM/YYYY	Yes	No	Unknown
<input type="checkbox"/> Asymptomatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Generalised lymphadenopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Generalised dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unexplained persistent parotid enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hepatosplenomegaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recurrent diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recurrent/chronic upper respiratory tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pulmonary tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Failure to thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Multiple or recurrent bacterial infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurological involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Oesophageal candidiasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recurrent lower respiratory tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cytomegalovirus retinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Extrapulmonary tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clinical Notes:

ANTIRETROVIRAL THERAPY (INFANT/CHILD)

ARV	Dosage	Actual Duration Received (weeks)	Comments
<input type="checkbox"/> Nevirapine			
<input type="checkbox"/> Zidovudine			
<input type="checkbox"/> Lamivudine			
<input type="checkbox"/> Abacavir			
<input type="checkbox"/> Lopinavir/Ritonavir			
<input type="checkbox"/> Dolutegravir			
<input type="checkbox"/> Tenofovir			
<input type="checkbox"/> Other (specify):			

Current Status of Patient:

<input type="checkbox"/> Pending	<input type="checkbox"/> Advanced HIV	<input type="checkbox"/> AIDS	<input type="checkbox"/> AIDS Death
<input type="checkbox"/> HIV	<input type="checkbox"/> 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:

i. (immediate cause)	ii. (intermediate cause)	iii. (underlying cause)
-------------------------	-----------------------------	----------------------------

NAME OF CASE: _____

MEDICAL RECORD NUMBER: _____

MOTHER'S INFORMATION

Mother's ID Type: <input type="checkbox"/> Driver's License <input type="checkbox"/> TRN <input type="checkbox"/> Passport <input type="checkbox"/> 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 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 Docket Number:	Treatment Site:
HIV Status of Mother: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date of Mother's Confirmatory HIV Test: DD/MM/YYYY
Laboratory where Mother's confirmatory HIV test performed:	
<input type="checkbox"/> National Public Health Laboratory	<input type="checkbox"/> University Hospital of the West Indies
<input type="checkbox"/> Other	<input type="checkbox"/> Other Government Laboratory Facility

Site of Delivery:

Gravida:

Parity:

Treatment During Pregnancy

Antenatal ARV Treatment	ART Start Date(DD/MM/YYYY)	Antenatal ARV Treatment	ART Start Date(DD/MM/YYYY)
<input type="checkbox"/> Tenofovir/Lamivudine		<input type="checkbox"/> Atazanavir/Ritonavir	
<input type="checkbox"/> Tenofovir/Emtricitabine		<input type="checkbox"/> Darunavir/Ritonavir	
<input type="checkbox"/> Abacavir/Lamivudine		<input type="checkbox"/> Zidovudine/Lamivudine	
<input type="checkbox"/> Dolutegravir		<input type="checkbox"/> Nevirapine	
<input type="checkbox"/> Lopinavir/Ritonavir		<input type="checkbox"/> Other (specify):	

Antenatal Care (this pregnancy):

<input type="checkbox"/> Public Hospital	<input type="checkbox"/> Private Doctor	<input type="checkbox"/> Health Centre
<input type="checkbox"/> Private Hospital	<input type="checkbox"/> Private Obstetrician	<input type="checkbox"/> None

Mother's Next of Kin

First Name:	Last Name:		
Phone number:	Email address:		
Address: Lot/ Street/Community/Parish:			
Relationship to the Mother:			
<input type="checkbox"/> Husband	<input type="checkbox"/> Daughter	<input type="checkbox"/> Aunt	<input type="checkbox"/> Friend
<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other
<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandfather	
<input type="checkbox"/> Son	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	

NAME OF CASE: _____

MEDICAL RECORD NUMBER: _____

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: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date of Father's Confirmatory HIV Test: DD/MM/YYYY

Laboratory where Father's confirmatory HIV test performed:

<input type="checkbox"/> National Public Health Laboratory	<input type="checkbox"/> University Hospital of the West Indies	<input type="checkbox"/> Other Government Laboratory Facility
<input type="checkbox"/> Other - Unkown		

SAMPLE AND LAB INFORMATION

HIV Testing for Infant/Child	Date (DD/MM/YYYY)	Result	Comment
<input type="checkbox"/> PCR at birth		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> 2-Week PCR (if high risk)		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> 6-Week PCR		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> 4-Month PCR		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> 18-Month ELISA		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> Determine Rapid Antibody		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> Uni-Gold Rapid Antibody		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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 CASE: _____

MEDICAL RECORD NUMBER: _____

Definitions (Diagnosis by physician)

Advanced HIV

(Infant/child < 5 years): Age < 12 months, CD4% < 30%; Age 12 – 35 months, CD4% < 25%; Age 36 – 59 months, CD4% < 20%; Age < 5 years; CD4 count 200 – 349 cells/ul.

Asymptomatic

No symptoms or signs suggestive of HIV infection.
Enlargement of liver and/or spleen.

Hepatosplenomegaly

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.

Generalised lymphadenopathy

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.

**Cytomegalovirus retinitis
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

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

Two or more episodes of lower respiratory tract infections within a 6-month period

Tract infections

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)