CHILD WITH PERINATAL EXPOSURE TO HIV

Australian Paediatric Surveillance Unit

Please contact the APSU (02) 9845 3005 or SCHN-APSU@health.nsw.gov.au if you have any questions about this form

APSU Office Use Only

Study ID #:

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided.
DK = Don't Know; NA = Not Applicable; NK = Not Known

Version 2.1_03/02/2021

1. NOTIFYING DOCTOR:

APSU Dr Code/Name: ☐☐☐☐/_____ Date questionnaire completed: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

2. IDENTIFICATION OF THE CHILD:

First 2 letters of first name: ☐☐

First 2 letters of surname: ☐☐

Date of Birth: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

Sex Registered at Birth: ☐ Male ☐ Female ☐ Other – specify: _____

3. IDENTIFICATION OF THE MOTHER WITH HIV INFECTION:

First 2 letters of first name: ☐☐

First 2 letters of surname: ☐☐

Date of Birth: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

4. OTHER CHARACTERISTICS OF THE CHILD:

Child's country of birth: ☐ Australia ☐ Other *(please specify):* _____

If the child was ***born in Australia***, in which State/Territory was the child born? : ☐☐☐

If the child was ***born overseas***, state year of arrival in Australia: ☐☐☐☐ *(YYYY)*

Birthweight: _____ grams

Gestational age: _____ weeks

State/Territory of residence of the child: ☐☐☐

Postcode of usual place of residence: ☐☐☐☐

Is the child of Aboriginal or Torres Strait Islander descent? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

*(For persons of **both Aboriginal and Torres Strait Islander** descent, tick both "Yes" options)*

What language does the child mostly speak at home? *(If applicable)* ☐ English ☐ Other *(please specify):* _____

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to the APSU

Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child: ***Name:*** ***Hospital:***

5. LABORATORY TESTING FOR HIV INFECTION:

Laboratory number: _____

When was the child last tested for HIV infection? : __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

What was the result of the last test? ☐ Negative ☐ Indeterminate ☐ Positive ☐ Not Known

If the child is HIV positive: Place of child's first ever HIV diagnosis:	☐ Australia ☐ Overseas
Specify the Australian State/Teritory of child's first ever HIV diagnosis in Australia:	_____
Specify the date of child's first ever HIV diagnosis in Australia:	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
Specify the country if child's first ever HIV diagnosis if overseas:	_____
Specify the date of child's first ever HIV diagnosis if overseas:	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
HIV Type:	☐ HIV-1 ☐ HIV-2 ☐ HIV-1 & HIV-2
Earliest CD4+ count after this diagnosis?	☐☐☐☐ (cells/µl)
Date of CD4+ cell count:	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
Earliest viral load after this HIV diagnosis?	☐☐☐☐☐☐☐ (RNA copies/ml)
Date of viral load:	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
What was the clinical status of the child at the date of specimen collection for this HIV diagnosis? *(Tick as many boxes as appropriate)*	☐ Asymptomatic for HIV ☐ Symptoms consistent with primary HIV infection (HIV seroconversion illness) [1] ☐ AIDS defining illness [2] ☐ Other symptoms – specify: _____ ☐ Other symptoms of HIV – specify: _____ ☐ Deceased (please complete questions in Section 7)
Does the child report a history of symptoms consistent with seroconversion illness? [1]	☐ Yes ☐ No
If Yes, date of symptomatic onset:	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

6. CHILD'S HIV TESTING HISTORY:

Has the child had a previous laboratory HIV test?	☐ Yes ☐ No ☐ Not reported
If Yes, when was last HIV laboratory test?	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
What was the result of the previous laboratory HIV test?	☐ Negative ☐ Indeterminate
Who reported the result of the previous negative or indeterminate laboratory HIV test?	☐ Parent / guardian / child ☐ Doctor ☐ Laboratory
Has the child had a previous non-laboratory HIV test?	☐ Yes ☐ No ☐ Not reported
If Yes, when was last HIV non-laboratory test?	__ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*
What was the result of the previous non-laboratory HIV test?	☐ Non-reactive ☐ Invalid ☐ Reactive

What was the type of the previous non-laboratory HIV test?	☐ Rapid ☐ Self (home test) ☐ Other – specify: _____
Who reported the result of the previous non-laboratory HIV test?	☐ Parent / guardian / child ☐ Doctor

7. PERINATAL EXPOSURE TO HIV:

Was the child treated with antiretroviral therapy before her/his HIV infection status was known?

☐ Yes ☐ No ☐ Not known ***If YES***, date of commencement of therapy: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

Was the child treated with prophylactic therapy before her/his HIV infection status was known?

☐ Yes ☐ No ☐ Not known ***If YES***, date of commencement of therapy: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

8. CURRENT STATUS OF THE CHILD:

☐ Child is alive, date of most recent contact: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

☐ Child has died, date of death: __ __ / __ __ / __ __ __ __ *(dd/mm/yyyy)*

What was the cause of death?

☐ AIDS defining illness [2]
☐ Accidental
☐ Non-AIDS defining illness
☐ Drug overdose
☐ Heart or vascular disease
☐ Liver disease
☐ Suicide
☐ Not reported
☐ Other cause – specify: _____

Source of information on the death: ☐ Doctor ☐ State / Territory ☐ Other – specify: _____

Footnotes:

[1] Seroconversion illness may occur 2-4 weeks following exposure to HIV and is characterised by fever, lethargy, anorexia, pharyngitis, headaches, myalgias and arthralgias and lymphadenopathy.

[2] Center for Disease Control list of AIDS defining illnesses from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5710a2.htm

Information is sought on the child's mother and her risk factors for perinatal HIV transmission.

Would you either:

Complete the case report form titled "Mother with perinatally exposed children" via the secure online link:

https://redcap.sydney.edu.au/surveys/?s=9RKD388CMJ

or download and complete a printed copy of the questionnaire:

http://apsu.org.au/assets/current-studies/HIV-Mother-Questionnaire-V1.1.pdf

If you are unable to complete the form, please forward to the doctor providing the mother's HIV care.

Thank you for your help with this research project.

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au
or fax to 02 9845 3082
or mail to: Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145
- even if you don't complete all items.

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and Faculty of Medicine and Health, The University of Sydney.
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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.

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