**Date:**
**Worker:**
**Address:**

Dear:

I am responding to your request for information regarding _____
DOB:_____

(To the Physician: Please checks the appropriate boxes below)

_____ Initial Diagnosis
_____ Six-Month Update
_____ Change in Status Since Last Report

Based on accepted diagnostic procedures, the above named foster child has the following classifications:

Levels (Corresponding to classification established by the National Center for Disease Control)

| | | |
|---|---|---|
| ____ | E | Perinatally exposed infant 0-24 months who cannot be classified as definitely infected, who has the antibody to HIV, indicating exposure to an infected mother. |
| ____ | N | Infant, child or youth, who meets one of the CDC definitions for infection, but has no previous signs or symptoms of HIV. |
| ____ | A, B, C | A=Mild Signs/Symptoms<br>B=Moderate Signs/Symptoms<br>C=Severe Signs/Symptoms |
| ____ | T | Child aged 0-21 with laboratory evidence of HIV infection who has a resulting terminal diagnosis with a life expectancy of less than six months. |
| ____ | Seroreversion | Infant, formerly classified as E who has achieved at least age 18 months, has not developed HIV infection and is no longer considered to be at risk of infection from perinatal exposure. |

Physician's Signature _____ ,M.D.
Address _____
_____