Perinatal HIV Exposure Case Report Form

Mail completed form to:

Rhode Island Department of Health, Center for HIV, Hepatitis, STDs, and TB Epidemiology

3 Capitol Hill, Room 106, Providence, RI 02908

Phone: 401-222-2577, Fax: 401-222-6001

I. Reporting Information:

Date Reported to RIDOH	Facility Reporting	Person Reporting	Phone Number

II. Maternal Information:

Name (First, Middle, Last)	Date of Birth	Phone Number

Street Address	City	County	State	ZIP Code

Country of Birth
☐ USA ☐ Other / US Dependency
Please specify: ______________________

Ethnicity
☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Unknown

Race (*check all that apply*)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown
☐ Other, specify: ______________________

Biological mother's HIV infection status
☐ Refused HIV testing ☐ Known HIV+ before pregnancy ☐ Known HIV+ during pregnancy ☐ Known HIV+ sometime before birth
☐ Known HIV+ at time of delivery ☐ Known HIV+ sometime after birth ☐ Unknown

Maternal Risk
☐ Perinatally acquired HIV infection
☐ Injected non-prescription drugs

HETEROSEXUAL relations with any of the following:
☐ Intravenous/injection drug user ☐ Bisexual Male
☐ Transfusion recipient with documented HIV infection
☐ Male with documented HIV infection, risk unspecified
☐ Male with hemophilia/coagulation disorder
☐ Transplant recipient with documented HIV infection

Date pregnancy began	Date prenatal care began	Date of Diagnosis
____/____/______	____/____/______	____/____/______

III. Pregnancy, Labor, and Delivery:

Mom's Last Viral Load Prior to Delivery
Date: ____/____/____
Result:

Mom's Last CD4 Prior to Delivery
Date: ____/____/____
Result:

Were antiretroviral drugs prescribed for the mother during *this pregnancy*? ☐ **Yes** (*Complete Table*) ☐ **No**

Drug name	Date drug started	Gestational age (wks)	Date stopped
i.__________________	____/____/____	__________	____/____/____
ii.__________________	____/____/____	__________	____/____/____
iii.__________________	____/____/____	__________	____/____/____

Did mother receive antiretroviral drugs during *labor and delivery*? ☐ **Yes** (*Complete Table*) ☐ **No**

Drug name	Drug Refused	Date received (mm/dd/yyyy)	Time received (AM/PM)	Type of administration: Oral	IV	Unk
i.__________________	☐	____/____/______		☐	☐	☐
ii.__________________	☐	____/____/______		☐	☐	☐
iii.__________________	☐	____/____/______		☐	☐	☐

Type of Delivery
☐ Single ☐ Twin ☐ >2

Delivery Method ☐ Vaginal ☐ Elective caesarean ☐ Non-elective caesarean ☐ Caesarean, unknown type
Neonatal Status ☐ Full Term ☐ Premature ☐ Unknown **Neonatal Status Weeks**: __________

Facility at Birth	Birth Weight (lbs)	Birth Defects

IV. Infant Postpartum Care:

Infant's Name (First, Middle, Last)	Sex	Date of Birth
	☐ Female ☐Male	

Ethnicity
☐ Not Hispanic or Latino
☐ Hispanic or Latino ☐ Unknown

Race (check all that apply)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Unknown ☐ Other, specify: ______________________

Date of Initial HIV Testing	Type of Initial HIV Test	Results:
____/____/______	☐ HIV -1 RNA/DNA NAAT (Quant)	

	☐ Other, specify: ________________

IV. Infant Postpartum Care (continued)

Were antiretroviral drugs prescribed for the infant after delivery? ☐ **Yes** *(Complete Table)* ☐ **No**

Drug name	Drug refused	Date drug started	Drug stopped	Date stopped
i.________________________	☐	____/_____/____	☐	____/_____/____
ii.________________________	☐	____/_____/____	☐	____/_____/____
iii.________________________	☐	____/_____/____	☐	____/_____/____

V. Provider Information

Infant's General Pediatrician		**Infant's HIV Specialty Pediatrician**
Infant's Case Manager (Person & Organization)		
Infant's Primary Caregiver ☐ Mother ☐ Other, specify: ______________________	**Phone Number**	**Relationship**

General comments

VI. Infant Follow Up Test Information (For RIDOH Use Only)

HIV Test Date	HIV Test Type	HIV Test Result	HIV Test Date	HIV Test Type	HIV Test Result

Infant Final Disposition: ☐ HIV-negative ☐ HIV-positive ☐ Unknown

Date Closed: **RIDOH Staff:**

VII. eHARS Data Entry (For RIDOH Use Only)

Maternal Soundex:	**Maternal Stateno:**	**Infant Stateno:**
Maternal Race:	**Maternal Ethnicity:**	**Maternal Country of Birth:**
Maternal Risk:	**Maternal Diagnosis:**	