Pregnancy and HIV Case Report Form

Mail completed form to:
Rhode Island Department of Health, Center for HIV, Hepatitis, STDs, and TB Epidemiology
3 Capitol Hill, Room 106A, Providence, RI 02908 Tel: 401-222-2577

Pregnancy with a chronic infectious disease is REPORTABLE TO RIDOH WITHIN FOUR BUSINESS DAYS OF KNOWLEDGE OF THE PREGNANCY. Use this form to report HIV-infected pregnant women.

I. Reporting Information:

Date Reported to RIDOH	Person Reporting	Reporting Facility

II. Maternal Prenatal Care:

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

Street Address	City	County	State	ZIP Code

Country of Origin
☐ 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: _____

Currently pregnant?	Date Prenatal Care Began	Expected date of delivery	Expected location of delivery
☐ Yes ☐ No	____/____/____	____/____/____	

If no, pregnancy outcome
☐ Live birth (*complete remaining sections)* **Date of outcome** ____/____/____
☐ Spontaneous or induced abortion
☐ Still birth **Facility** _____

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

Drug name	Drug refused	Date drug started	Gestational age (wks)	Drug stopped	Date stopped
i._____	☐	____/____/____	_____	☐	____/____/____
ii._____	☐	____/____/____	_____	☐	____/____/____
iii._____	☐	____/____/____	_____	☐	____/____/____
iv._____	☐	____/____/____	_____	☐	____/____/____

Mother's Primary Care Provider	Mother's HIV Medical Provider	Mother's Obstetrician

Mother's Case Manager (Person and Organization)