# 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 106A, Providence, RI 02908 Tel: 401-222-2577

## 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 | State Number / Soundex |
|---|---|---|---|
| | | | |

| 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: _____

**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**
HETEROSEXUAL relations with any of the following:
☐ Perinatally acquired HIV infection ☐ Intravenous/injection drug user ☐ Bisexual Male ☐ Male with hemophilia/coagulation disorder
☐ Injected non-prescription drugs ☐ Transfusion recipient with documented HIV infection ☐ Transplant recipient with documented HIV infection

**Date pregnancy began** _____/_____/_____ **Date prenatal care began** _____/_____/_____

## III. Labor and Delivery:

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

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

**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._____ | ☐ | ____/____/_____ | | ☐ | ☐ | ☐ |
| iv._____ | ☐ | ____/____/_____ | | ☐ | ☐ | ☐ |

**Type of Delivery**
☐ Single ☐ Twin ☐ >2

**Delivery Method** ☐ Vaginal ☐ Elective caesarean ☐ Non-elective caesarean ☐ Caesarean, unknown type

| Facility at Birth | Birth Weight (lbs) | Birth Defects |
|---|---|---|
| | | |

## IV. Infant Postpartum Care:

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

**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**<br>☐ Mother ☐ Other, specify: _____ | **Phone Number** | **Relationship** |
| **General comments** | | |
| | | |
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| | | |
| | | |
| | | |
| | | |

## VI. Infant Follow Up Test Information (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:**