Perinatal HIV Exposure Case Report Form

Mail completed form to:
Rhode Island Department of Health, Center for HIV, Hepatitis, STDs, and TB Epidemiology
Room 106A, 3 Capitol Hill, 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 No.	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
☐ Perinatally acquired HIV infection
☐ Injected non-prescription drugs
HETEROSEXUAL relations with any of the following:
☐ Intravenous/injection drug user ☐ Bisexual Male ☐ Male with hemophilia/coagulation disorder
☐ 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 Care Giver ☐ Mother ☐ Other, specify: _____	**Phone Number**	**Relationship**
General comments		

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:**