Reporting HIV and AIDS in Iowa

What's reportable AIDS has been a reportable disease in Iowa since February 1983. HIV became reportable by name in Iowa on July 1, 1998. **Iowa Administrative Code 641.11.6.**, below, details reporting.

641—11.6(141A) Reporting of diagnoses and HIV-related tests, events, and conditions to the department.

11.6(1) The following constitute reportable events related to HIV infection:

a. A test result indicating HIV infection, including:

(1) Confirmed positive results on any HIV-related test or combination of tests, including antibody tests, antigen tests, cultures, and nucleic acid amplification tests.

(2) A positive result or report of a detectable quantity on any other HIV detection (non-antibody) tests, and results of all viral loads, including nondetectable levels.

b. AIDS and AIDS-related conditions, including all levels of CD4+ T-lymphocyte counts.

c. Birth of an infant to an HIV-infected mother (perinatal exposure) or any (positive, negative, or undetectable) non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger.

d. Death resulting from an AIDS-related condition, or death of a person with HIV infection.

11.6(2) Within seven days of the receipt of a person's confirmed positive test result indicating HIV infection, the director of a plasma center, blood bank, clinical laboratory or public health laboratory that performed the test or that requested the confirmatory test shall make a report to the department on a form provided by the department.

11.6(3) Within seven days of the receipt of a test result indicating HIV infection, which has been confirmed as positive according to prevailing medical technology, or immediately after the initial examination or treatment of a person infected with HIV, the physician or other health care provider at whose request the test was performed or who performed the initial examination or treatment shall make a report to the department on a form provided by the department.

11.6(4) Within seven days of diagnosing a person as having AIDS or an AIDS-related condition, the diagnosing physician shall make a report to the department on a form provided by the department.

11.6(5) Within seven days of the death of a person with HIV infection, the attending physician shall make a report to the department on a form provided by the department.

11.6(6) Within seven days of the birth of an infant to an HIV-infected mother or a receipt of a laboratory result (positive, negative, or undetectable) of a non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger, the attending physician shall make a report to the department on a form provided by the department.

11.6(7) The report shall include:

a. The person's name, address, date of birth, gender, race and ethnicity, marital status, and telephone number.

b. The name, address and telephone number of the plasma center, blood bank, clinical laboratory or public health laboratory that performed or requested the test, if a test was performed.

c. The address of the physician or other health care provider who requested the test.

d. If the person is female, whether the person is pregnant.

11.6(8) All persons who experience a reportable event while receiving services in the state, regardless of state of residence, shall be reported.

Need reporting forms? Want to call in a report? Have questions? Need surveillance data?

Alagie "Al" Jatta, HIV Surveillance Coordinator: 515-242-5141 Alagie.Jatta@idph.iowa.gov,
Jessica Morris, HIV Surveillance Epidemiologist: 515-281-6918 Samoane.Don@idph.iowa.gov ;

For free postpaid "03 CONFIDENTIAL" envelopes, call the Clearinghouse at 1-888-398-9696

COMPLETED FORMS MAY BE SENT VIA THE U.S. POSTAL SERVICE OR YOU CAN USE THE FORM TO COLLECT THE REQUIRED DATA AND THEN CALL US. FAXING OR EMAILING OF COMPLETED FORMS IS NOT ALLOWED!

By Mail:

Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319
"03 Confidential"

By Phone:

Alagie Jatta at 515-281-6918

INSTRUCTIONS

Don't panic. The form can seem a little foreboding. We do not expect you to know everything on the form, but we do expect you to provide all of the requested information that is known to you.

Additional information. The form is the standard CDC report form. It asks for standard CDC information. In addition to the standard information, please use the comment sections of the form to provide any information you may have on the following:

- Mother's living situation (Who knows about her HIV status? Who doesn't?)
- Mother's marital or relationship status (including HIV status of partners)
- Maintaining patient confidentiality is supremely important. With this in mind, what is the best way (e.g., a specific phone telephone number, time or place) for a trained Disease Prevention Specialist to contact the mother to provide education about HIV, link her to available resources for her and the infant, and offer other assistance as appropriate?
- Other places, either in Iowa or out-of-state, the mother may have lived?
- Mother's Social Security Number

Questions? Please call 515-281-6918.

Thank you! Thank you for complying with Iowa's HIV reporting statutes!

Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Birth, Call Me)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( ) _____	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type	*Number	

U.S. Department of Health & Human Services

Pediatric HIV Confidential Case Report Form

(Patients <13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control and Prevention

Form approved OMB no. 0920-0573 Exp. 06/30/2019

Health Department Use Only (record all dates as mm/dd/yyyy)

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID _____	State Number _____
Reporting Health Dept - City/County	City/County Number	
Document Source _____	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 6-CD/Disk	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( ) _____
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	*Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____	*Other Facility:* ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form		*Phone ( ) _____

Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report ☐ 3-Perinatal HIV Exposure ☐ 4-Pediatric HIV ☐ 5-Pediatric AIDS ☐ 6-Pediatric Seroreverter	Sex assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US Dependency (please specify) _____
Date of Birth __ __/__ __/__ __ __ __	Alias Date of Birth __ __/__ __/__ __ __ __	
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __/__ __/__ __ __ __	State of Death _____
Date of Last Medical Evaluation __ __/__ __/__ __ __ __	Date of Initial Evaluation for HIV __ __/__ __/__ __ __ __	
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity _____	
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race _____	

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Type (Check all that apply to address below)	☐ Residence at HIV diagnosis	☐ Residence at AIDS diagnosis	☐ Residence at Perinatal Exposure	☐ Residence at Pediatric Seroreverter	☐ Check if SAME as Current Address
* Street Address					Address Date __ __/__ __/__ __ __ __
City	County	State/Country			*ZIP Code

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: (PRA (0920-0573). **Do not send the completed form to this address.**

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.)

_____ *Phone ( ) _____

Hospital/Facility _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (Check all that apply to facility below) ☐ HIV ☐ AIDS ☐ Perinatal Exposure ☐ Check if SAME as Facility Providing Information

Facility Name			***Phone** ( ) _____
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**

Facility Type
Inpatient: ☐ Hospital ☐ Other, specify _____
Outpatient: ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____
Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____

***Provider Name**	***Provider Phone** ( ) _____	**Specialty**

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Child's biological mother's HIV infection status (select one): ☐ Refused HIV testing ☐ Known to be uninfected after this child's birth ☐ Known HIV+ before pregnancy ☐ Known HIV+ during pregnancy ☐ Known HIV+ sometime before birth ☐ Known HIV+ at delivery ☐ Known HIV+ after child's birth ☐ HIV+, time of diagnosis unknown ☐ HIV status unknown

Date of mother's first positive HIV confirmatory test: __ __ /__ __ /__ __ __ __	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? ☐ Yes ☐ No ☐ Unknown

After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV infection	☐ Yes ☐ No ☐ Unknown
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received __ __ / __ __ / __ __ __ __ Last date received __ __ / __ __ / __ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Before the diagnosis of HIV infection, this child had:	
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder Specify clotting factor: Date received: __ __ / __ __ / __ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received __ __ / __ __ / __ __ __ __ Last date received __ __ / __ __ / __ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Laboratory Data (record additional tests and tests not specified in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Non-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

TEST 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT*: HIV-1 Ag
☐ Reactive ☐ Nonreactive ☐ Not Reported
Collection Date: __ __ /__ __ /__ __ __ __

HIV-Ab
☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV Ab

HIV Detection Tests (Qualitative)

TEST: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

First CD4 result <200 cells/µL or <14%: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Other CD4 result: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If laboratory tests were not documented, is patient confirmed by a physician as:
HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis:** __ __ /__ __ /__ __ __ __
Not HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis:** __ __ /__ __ /__ __ __ __

Clinical (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary†	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary†	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

†If TB selected above, indicate RVCT Case Number:

Birth History (for Perinatal Cases only)

Residence at Birth

Birth History Available ☐ Yes ☐ No ☐ Unknown | ☐ Check if SAME as Current Address

*** Street Address** | **City**

County | **State/Country** | ***ZIP Code**

Facility of Birth

☐ Check if SAME as Facility Providing Information

Facility Name of Birth (if child was born at home, enter "home birth") | ***Phone** ( ) _____ | ***ZIP Code**

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Other, specify _____ *Other Facility:* ☐ Emergency Room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address** | **City** | **County** | **State/Country**

Birth History

Birth Weight _____ lbs _____ oz _____ grams | **Type** ☐ 1-Single ☐ 2-Twin ☐ 3->2 ☐ 9-Unknown | **Delivery** ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Non-Elective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown

Birth Defects ☐ Yes ☐ No ☐ Unknown | **If yes, please specify:**

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ Unknown | **Neonatal Gestational Age in Weeks:** _____ (99–Unknown)

Gestational Month Prenatal Care Began _____ (00-None, 99-Unknown) | **Prenatal Care – Total number of prenatal care visits:** _____ (00-None, 99-Unknown)

Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Maternal Information

Maternal DOB | **Maternal Last Name Soundex** | **Maternal Stateno** | **Maternal Country of Birth**

***Other Maternal ID – List Type** | **Number**

Services Referrals (record all dates as mm/dd/yyyy)

This child received or is receiving:

Neonatal ARVs for HIV prevention: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

If Yes, please specify: 1) 2) 3) 4) 5)

Anti-retroviral therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

Was this child breastfed? ☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is: ☐ 1- Biological Parent ☐ 2- Other Relative ☐ 3- Foster/Adoptive parent, relative ☐ 4- Foster/Adoptive parent, unrelated ☐ 7- Social Service Agency ☐ 8- Other (please specify in comments) ☐ 9- Unknown

Comments

*Local/Optional Fields

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

IOWA DEPARTMENT OF PUBLIC HEALTH

Perinatal HIV Exposure Reporting (PHER)

Infant's State Number _____ Mother's State Number _____

Infant's City Number _____ Mother's City Number _____

Form Approved OMB No. 0920-0573 Exp. Date 06/30/2019

1. If information on the mother is not available, was the child adopted, or in foster care?

☐ Yes ☐ No ☐ Not applicable

2. Records abstracted

(**1** = Abstracted, **2** = Attempted—record not available, **3** = Not abstracted, **4** = Attempted—will try again)

_____Prenatal care records

_____Maternal HIV clinic records

_____Labor and delivery records

_____Pediatric birth records

_____Pediatric HIV medical records

_____Pediatric medical records (non-HIV clinic or provider)

_____Birth certificate

_____Death certificate

_____Health department records

_____Other (Specify) _____

3. Weeks' gestation at first prenatal care visit

___ ___ weeks

4. Was the mother screened for any of the following during pregnancy?

(Check test(s) performed before birth, but closest to date of delivery or admission to labor and delivery)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Group B strep	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Hepatitis B (HBsAg)	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Rubella	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Syphilis	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐

5. Diagnosis (for the mother) of the following conditions during this pregnancy or at the time of labor and delivery

(See instructions for data abstraction for definitions)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Bacterial vaginosis	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Chlamydia trachomatis infection	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Genital herpes	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Gonorrhea	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Group B strep	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Hepatitis B (HbsAg+)	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Hepatitis C	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
PID	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Syphilis	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐
Trichomoniasis	☐	__ __/__ __/__ __ __ __	☐	☐	☐	☐

6. Mother's reproductive history

_____No. of previous pregnancies

_____No. of previous miscarriages or stillbirths

_____No. of previous live births

_____No. of previous induced abortions **OR** _____Total No. of previous abortions

7. Complete the chart for all siblings.

	Date of birth (mm/dd/yyyy)	Age (yrs: mos as of mm/yyyy)	HIV serostatus (See list below)	State Number	City Number
Sib 1	__ __/__ __/__ __ __ __	__:__ as of __ __/__ __/__ __ __ __	_____	_____	_____
Sib 2	__ __/__ __/__ __ __ __	__:__ as of __ __/__ __/__ __ __ __	_____	_____	_____
Sib 3	__ __/__ __/__ __ __ __	__:__ as of __ __/__ __/__ __ __ __	_____	_____	_____
Sib 4	__ __/__ __/__ __ __ __	__:__ as of __ __/__ __/__ __ __ __	_____	_____	_____

HIV serostatus: **1** = Infected, **2** = Not infected, **3** = Indeterminate, **9** = Not documented, **U** = Unknown

8. Was substance use during pregnancy noted in the medical or social work records?

☐ Yes ☐ No (**Go to 9**) ☐ Record not available (**Go to 9**) ☐ Unknown

8a. If yes, indicate which substances were used during pregnancy. (Check all that apply)

☐ Alcohol ☐ Cocaine ☐ Marijuana (cannabis, THC, cannabinoids) ☐ Opiates
☐ Amphetamines ☐ Crack cocaine ☐ Methadone ☐ Other (Specify) _____
☐ Barbiturates ☐ Hallucinogens ☐ Methamphetamines ☐ Specific drug(s) not documented
☐ Benzodiazepines ☐ Heroin ☐ Nicotine (any tobacco product)

8b. If substances used, were any injected?

☐ Yes ☐ No ☐ Not documented ☐ Unknown ☐ Specify injected substance(s). _____

9. Was a toxicology screen done on the mother (either during pregnancy or at the time of delivery)?

☐ Yes, positive result (Check all that apply)

☐ Alcohol ☐ Cocaine ☐ Marijuana (cannabis, THC, cannabinoids) ☐ Opiates
☐ Amphetamines ☐ Crack cocaine ☐ Methadone ☐ Other (Specify) _____
☐ Barbiturates ☐ Hallucinogens ☐ Methamphetamines ☐ Specific drug(s) not documented
☐ Benzodiazepines ☐ Heroin ☐ Nicotine (any tobacco product)

☐ Yes, negative result
☐ No
☐ Toxicology screen not documented

10. Was a toxicology screen done on the infant at birth?

☐ Yes, positive result (Check all that apply)

☐ Alcohol ☐ Cocaine ☐ Marijuana (cannabis, THC, cannabinoids) ☐ Opiates
☐ Amphetamines ☐ Crack cocaine ☐ Methadone ☐ Other (Specify) _____
☐ Barbiturates ☐ Hallucinogens ☐ Methamphetamines ☐ Specific drug(s) not documented
☐ Benzodiazepines ☐ Heroin ☐ Nicotine (any tobacco product)

☐ Yes, negative result
☐ No
☐ Toxicology screen not documented

11. Was the mother's HIV serostatus noted in her prenatal care medical records?

☐ Yes, HIV-positive ☐ Yes, HIV-negative ☐ No ☐ No prenatal care ☐ Record not available ☐ Unknown

12. Were antiretroviral drugs prescribed for the mother during this pregnancy?

☐ Yes (**Complete table**) ☐ No (**Go to 12a**) ☐ Not documented (**Go to 13**) ☐ Record not available (**Go to 13**) ☐ Unknown (**Go to 13**)

	Drug name	**Drug refused**	**Date drug started** (mm/dd/yyyy)	**Gestational age drug started** (weeks; round down)	**Drug stopped** Yes	No	ND	**Date stopped** (if yes in preceding column) (mm/dd/yyyy)	**Stop codes** (See list on p. 4)
i.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____
ii.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____
iii.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____
iv.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____
v.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____
vi.	_____	☐	__/__/____	_____	☐	☐	☐	__/__/____	_____

(**After completing table, go to 13**)

12a. If no antiretroviral drug was prescribed during pregnancy, check reason.

☐ No prenatal care ☐ Mother known to be HIV-negative during pregnancy ☐ Not documented ☐ Unknown
☐ HIV serostatus of mother unknown ☐ Mother refused ☐ Other (Specify) _____

13. Was mother's HIV serostatus noted in her labor and delivery records?

☐ Yes, HIV-positive ☐ Yes, HIV-negative ☐ No ☐ Record not available ☐ Unknown

14. Did mother receive antiretroviral drugs during labor and delivery?

☐ Yes (**Complete table**) ☐ No (**Go to 14a**) ☐ Not documented (**Go to 15**) ☐ Record not available (**Go to 15**) ☐ Unknown (**Go to 15**)

	Drug name	Drug refused	Date received (mm/dd/yyyy)	Time received (See military time)	Type of administration: Oral	IV	Not documented
i.	_____	☐	__/__/____	____:____	☐	☐	☐
ii.	_____	☐	__/__/____	____:____	☐	☐	☐
iii.	_____	☐	__/__/____	____:____	☐	☐	☐
iv.	_____	☐	__/__/____	____:____	☐	☐	☐
v.	_____	☐	__/__/____	____:____	☐	☐	☐
vi.	_____	☐	__/__/____	____:____	☐	☐	☐

(**After completing the table, go to 15**)

Military time: noon = 12:00; midnight = 00:00

14a. If no antiretroviral drug was received during labor and delivery, check reason.

☐ Precipitous delivery/STAT Cesarean delivery
☐ Prescribed but not administered
☐ HIV serostatus of mother unknown
☐ Birth not in hospital
☐ Mother tested HIV-negative during pregnancy
☐ Mother refused
☐ Other (Specify) _____
☐ Not documented
☐ Unknown

15. Was mother referred for HIV care after delivery?

☐ Yes ☐ No (**Go to 17**) ☐ Not documented (**Go to 17**) ☐ Record not available (**Go to 17**) ☐ Unknown

16. If yes, indicate mother's first CD4 result or first viral load result after discharge from hospital

(up to 6 months after discharge).

16a. CD4 result

☐ Not done ☐ Not available

Result	Unit	Date blood drawn (mm/dd/yyyy)
____	cells/µL	__/__/____
__	%	__/__/____

16b. Viral load result

☐ Not done ☐ Not available

Result in copies/mL	Result in logs	Date blood drawn (mm/dd/yyyy)
_____	_____	__/__/____

17. Birth information

☐ **Birth not in hospital** ☐ **Record not available**

	Time (See military time)	Date (mm/dd/yyyy)		Time (See military time)	Date (mm/dd/yyyy)
Onset of labor	__:__	__/__/____	Rupture of membranes	__:__	__/__/____
Admission to labor and delivery	__:__	__/__/____	Delivery	__:__	__/__/____

Military time: noon = 12:00; midnight = 00:00

18. If Cesarean delivery, mark all the following indications that apply.

☐ HIV indication (high viral load)
☐ Previous Cesarean (repeat)
☐ Malpresentation (breech, transverse)
☐ Prolonged labor or failure to progress
☐ Mother's or physician's preference
☐ Fetal distress
☐ Placenta abruptia or p. previa
☐ Other (*e.g., herpes, disproportion*) (Specify)_____
☐ Not specified
☐ Not applicable

19. Was mother's HIV serostatus noted on the child's birth record?

☐ No ☐ Yes, HIV-positive ☐ Yes, HIV-negative ☐ Record not available ☐ Unknown

20. Were antiretroviral drugs prescribed for the child?

☐ Yes (**Complete table**) ☐ No (**Go to 20a**) ☐ Not documented ☐ Record not available ☐ Unknown

	Drug name	Drug refused	Date drug started (mm/dd/yyyy)	Time started (See military time)	Drug stopped Yes	No	ND	UNK	Stop date (if therapy not completed) (mm/dd/yyyy)	Stop codes (See list)
i.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____
ii.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____
iii.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____
iv.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____
v.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____
vi.	_____	☐	__/__/____	___:___	☐	☐	☐	☐	__/__/____	_____

Military time: noon = 12:00; midnight = 00:00

20a. If no antiretroviral drug was prescribed, indicate reason.

☐ HIV serostatus of mother unknown
☐ Mother known to be HIV-negative during pregnancy
☐ Mother refused
☐ Other (Specify) _____
☐ Not documented

Stop codes (2 codes allowed; if more, choose the 2 most important)

S1 = Adverse events (toxicity, lack of tolerance)
S2 = ART completed
S3 = Drug resistance detected
S4 = Poor adherence
S5 = Inadequate effectiveness
S6 = Strategic treatment interruption (planned drug holiday)
S7 = Drug interactions
S8 = Mother's choice
S9 = Pregnancy
S10 = Child determined not to be HIV infected
S11 = Improving effectiveness
S12 = Improving convenience
S13 = Reason not indicated; unknown
S14 = Mother couldn't afford drugs
Sxx = Other reason

List of abbreviations

ART	antiretroviral therapy
ND	not documented
PCP	*Pneumocystis jirovecii* pneumonia [*jirovecii* is now preferred to *carinii;* abbreviation is the same]
PID	pelvic inflammatory disease
STAT	immediately (*statim*)

Comments

Please include comments or clinical information you consider relevant to the overall understanding of this child's HIV exposure or infection status. State the date and source of the information.