I. PATIENT INFORMATION

Patient's Name: _____ Telephone Number:( ) _____

Address City: _____ County: _____ State: _____ ZIP Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT Social Security Number*: *- Patient identifier information is not transmitted to CDC! -*

* This agency is requesting disclosure of your Socail Security number in accordance with IC 4-1-8-1; disclosure is voluntary and you will not be penalized for refusal.

PERINATAL EXPOSURE CONFIDENTIAL REPORT FOR CHILDREN BORN TO MOTHER WITH HIV INFECTION

State Form 54730 (R / 4-25)
INDIANA DEPARTMENT OF HEALTH

(If child is confirmed HIV Infected please use State Form 51202.)

DATE FORM COMPLETED: ___/___/___ (mo / day / yr)

State Patient Number: *(state use only)* | | | | | | | | | | |

II. DIAGNOSTIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: ☐ Perinatally HIV Exposed ☐ Seroreverter (Not infected with HIV)

DATE OF BIRTH: ___/___/___ (mo / day / yr)

SEX: _____Male _____Female

CURRENT STATUS: ☐Alive ☐Dead ☐Unk.

DATE OF DEATH: ___/___/___ (mo / day / yr)

STATE/TERRITORY OF DEATH: _____

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes ☐ No ☐ Unk. ☐

ETHNICITY *(select one)*: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unk.

RACE *(Circle one or more)*: American Indian or Alaskan Native; Asian; Black or African American; Native Hawaiian or other Pacific Islander; White; Unknown

DATE OF INITIAL EVALUATION FOR HIV INFECTION: ___/___/___ (mo / day / yr)

DATE OF LAST MEDICAL EVALUATION FOR HIV INFECTION: ___/___/___ (mo / day / yr)

COUNTRY OF BIRTH: _____U.S. _____Other*(please specify)*_____

III. MATERNAL HISTORY

_____ Mother's Name ___/___/___ DOB _____ Mother's State Patient No.

Birthplace of Mother:

☐ U.S. ☐ U.S. territories (including Puerto Rico) *please specify*_____

☐ Other *(specify)*:_____ ☐ Unknown

***Date of Mother's first positive HIV confirmatory test:** ___/___/___ (mo / day / yr)

Mother was counseled about HIV testing during this pregnancy, labor, or delivery: Yes ☐ No ☐ Unk. ☐

Mother's HIV infection status *(circle one)*:

Refused HIV testing; Known HIV+ during pregnancy; Known HIV+ sometime after birth; Known HIV negative after birth; Known HIV+ sometime before birth; HIV+ with time unknown; Known HIV+ before pregnancy; Known HIV+ at time of delivery; Unknown

After 1977, mother had:

	Yes	No	Unk.
Injected nonprescription drugs	☐	☐	☐
HETEROSEXUAL relations with:			
-Intravenous/injection drug user	☐	☐	☐
-Bisexual male	☐	☐	☐
-Male with hemophilia/coagulation disorder	☐	☐	☐
-Transfusion recipient with documented HIV infection	☐	☐	☐
-Transplant recipient with documented HIV infection	☐	☐	☐
- Male with AIDS or documented HIV infection, risk not specified	☐	☐	☐
-Received transfusion of blood/blood components (other than clotting factor)	☐	☐	☐
-Received transplant of tissue/organs or artificial insemination	☐	☐	☐

IV. LABORATORY DATA

**********PLEASE ATTACH LABS**********

(Record all tests)

	Positive	Negative	Indeterminate	Not Done	Test Date (mo/day/yr)
HIV-1 RNA/DNA NAAT (Qual)	☐	☐	☐	☐	___/___/___
HIV-2 RNA/DNA NAAT (Qual)	☐	☐	☐	☐	___/___/___
HIV 1/2 AG/AB	☐	☐	☐	☐	___/___/___
HIV-1 EIA	☐	☐	☐	☐	___/___/___
WESTERN BLOT	☐	☐	☐	☐	___/___/___
HIV 1/2 Type Differentiated Immunoassay (i.e. Multispot)	☐	☐	☐	☐	___/___/___

HIV VIRAL LOAD TEST: *(Record all tests)*

DETECTABLE (circle one) Yes No _____ Copies/ml TEST DATE ___/___/___ (mo / day / yr)

DETECTABLE (circle one) Yes No _____ Copies/ml TEST DATE ___/___/___ (mo / day / yr)

V. BIRTH HISTORY *(For PERINATAL EXPOSURES only.)*

Birth History was available for this child: ***(circle one)*** **Yes** **No*** ***If No, proceed to section VI.**

HOSPITAL AT BIRTH:

Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/ Country: _____ ZIP Code: _____ - _____

BIRTHWEIGHT:

(enter lbs/oz OR grams)

☐☐ lbs. ☐☐ oz.

☐☐☐☐ grams

NEONATAL STATUS:

☐ Full Term

☐ Premature

_____Weeks

BIRTH:

Type: ☐Single ☐ Twin ☐ >2 ☐ Unk.

Delivery: ☐ Vaginal ☐Cesarean ☐Elective Cesarean ☐ Nonelective Cesarean

☐ Cesarean, unknown ☐ Unknown

If Cesarean delivery, please circle all the following indications that apply:

HIV indication(high viral load) Previous Cesarean(repeat) Malpresentation(breech, transverse)

Prolonged labor or failure to progress Birthing person's or physican's preference Fetal distress

Placenta abruption or previa Other(e.g.,herpes, disproportion) Please Specify_____

Not Specified

Was a toxicology screen done on the infant after birth?

☐ Yes ☐ No ☐ Unknown

If Yes, **PLEASE ATTACH TOXICOLOGY SCREENING RESULTS**

Birth Defects: YES NO UNKNOWN

Specify type(s):_____

DID MOTHER RECEIVE ANTIRETROVIRALS (ART)?

During Pregnancy? *(circle one)*	Yes	No	Refused	Unknown	If yes, what week_____
During labor/delivery? *(circle one)*	Yes	No	Refused	Unknown	
Prior to this pregnancy? *(circle one)*	Yes	No	Unknown		

VI. PHYSICIAN'S INFORMATION

Infant's Physician's Name:_____ Telephone Number: ( )_____ Medical Record Number_____

Hospital/Facility:_____Person completing Form:_____Telephone Number: ( )_____

VII. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk	DATE STARTED
▪ Neonatal Anti-retrovirals therapy for HIV Prevention	☐	☐	☐	___/___/___ mo day yr
▪ Anti-retroviral therapy for HIV treatment	☐	☐	☐	___/___/___ mo day yr
▪ PCP prophylaxis	☐	☐	☐	___/___/___ mo day yr

Was child breastfed? *(circle one)*

Yes No Unk.

Was child given pre-masticated food? *(circle one)*

Yes No Unk.

This child has been enrolled at:

Clinical Trial *(circle one)*

NIH-sponsored Other

None Unk.

Clinic *(circle one)*

HRSA-sponsored Other

None Unk.

This child's medical treatment is primarily reimbursed by:

☐ Medicaid

☐ Private insurance/HMO

☐ No coverage

☐ Other Public Funding

☐ Clinical Trial/government program

☐ Unk.

This child's primary caretaker is (*circle one*):

Biological parent(s) Other Retlative Foster/Adoptive Parent, relative Foster/Adoptive Parent, unrelated Social Service Agency Unk

VIII. COMMENTS