**Post-Pregnancy Care Records Abstraction Form**

**\*\*Post-L&D Discharge through 6 months after delivery\*\***

|  |
| --- |
| Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Abstraction Completion Date: \_\_\_/\_\_\_/\_\_\_ Date of Discharge \_\_\_/\_\_\_/\_\_\_ |

1. This form collects information relating to the health care the mother or birthing person received after the delivery hospitalization. (check all that apply):

□ Evidence-based home visiting and/or other case management

□ Routine postpartum OB/gyn care record.

□ HIV care record.

□ Hospitalization record.

□ Other (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abstractor Please Note: For purposes of this form, questions refer to the post-pregnancy period of delivery discharge through 6 months after delivery unless otherwise specified as the 6-week post-partum period.

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| **Introductory Information** |

1. For each type of care, indicate where the services were received and the provider type. (check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Gynecological/Family Planning Care** | **General primary care** | **HIV Care** | **Pre-existing**  **Dx Follow-Up** | **Other care**  **(specify)** |
| Care not received | □ | □ | □ | □ |  |
| **Facility Type** | | | | | |
| OB/Gyn Private Practice | □ | □ | □ | □ |  |
| Internal Medicine/Family Practice Private Practice | □ | □ | □ | □ |  |
| Adult HIV specialty care center | □ | □ | □ | □ |  |
| County/Local Health Department | □ | □ | □ | □ |  |
| Managed Care Organization (MCO) or Health Maintenance Organization (HMO) | □ | □ | □ | □ |  |
| Community Health Center | □ | □ | □ | □ |  |
| Correctional facility | □ | □ | □ | □ |  |
| Clinic in a hospital | □ | □ | □ | □ |  |
| Indian health services/ Tribal/Urban | □ | □ | □ | □ |  |
| Unknown/Not Documented |  |  |  |  |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |
| **Provider Type** | | | | | |
| General primary care provider (internal medicine physician, family physician, nurse practitioner, physician assistant) | □ | □ | □ | □ | □ |
| Nurse Midwife | □ | □ | □ | □ | □ |
| Obstetrician | □ | □ | □ | □ | □ |
| Internist | □ | □ | □ | □ |  |
| Perinatologist | □ | □ | □ | □ | □ |
| HIV Specialist (e.g., Infectious Disease Specialist) | □ | □ | □ | □ | □ |
| Physician Assistant | □ | □ | □ | □ | □ |
| Unknown/Not documented | □ | □ | □ | □ | □ |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ | □ |

Additional comments: Please note any additional/clarifying comments related to the introductory information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Language Barriers and Translation Services** |

1. Did the childbearing parent speak and understand English?

□ Yes (*skip to #4*)

□ No *(specify)*:

□ Unknown/Not documented (*skip to #4*)

* 1. If no, were language services provided?

□ Yes (specify in which clinical or service setting): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No *(specify why not)*:

□ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to language barriers and translation services.

|  |
| --- |
| **Home Visit** |

1. Did the postpartum person receive a visit from an evidence-based home visitor or other type of case management home visit during the 6- weeks post-partum period?

□ Yes

□ No *(Skip to #9)*

1. What was the purpose for the home visit(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many weeks postpartum were the visit(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Were there any concerns identified at the home visit? Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Was this visiting service provided by Ryan White Funds?

□Yes

□No

□ Unknown/Undocumented

Additional comments: Please note any additional/clarifying comments related to home visits for the post-partum period.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Postpartum Care** |

1. Did the mother or birthing person receive routine postpartum care as recommended by ACOG?

□ Yes

□ No (*skip to #15*)

□ Unknown/Not documented (*skip to #15*)

1. How many weeks postpartum was the first visit? \_\_\_\_\_\_\_\_\_\_\_
2. What was the payor source for postpartum care? *(check all that apply)*

□ Private insurance

□ Managed care organization (MCO) or Health maintenance organization (HMO), private payor

□ Traditional Medicaid

□ Medicaid Managed care organization (MCO) or Health maintenance organization (HMO)

□ Medicaid, type unknown

□ Medicare

□ Ryan White

□ CHAMPUS/Military insurance

□ Self pay, but eligible for Medicaid

□ Self pay

□ Other *(specify)*:

1. Was there documentation in the post-partum OB/gyn record that the mother or birthing person was HIV positive?

□ Yes

□ No

1. Are any medications noted in the postpartum OB/gyn records that the mother or birthing person was taking during the post-pregnancy period? Include any information about prescriptions that the mother left the hospital with. Do not include contraceptives or ARVs.

□ Yes

□ No *(skip to #14)*

13a. If yes, list below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug Name** | **Date started** | **Drug Stopped?** | **Reason Drug Stopped** |
| I. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| II. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| III. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| IV. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| V. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |

1. Is there documentation that a second follow-up family planning/gynecological visit was scheduled?

□ Yes

□ No *(skip to #15)*

□ Mother or birthing person instructed to call to make an appointment

* 1. If yes, please specify facility type:

□ Private Provider’s office

□ Adult HIV specialty care center

□ County/Local Health Department

□ Managed Care Organization (MCO) or Health Maintenance Organization (HMO)

□ Community Health Center

□ Family Planning clinic (i.e. Planned Parenthood)

□ Correctional facility

□ Clinic at hospital

□ Indian health services/ Tribal/Urban

□ Unknown/Not Documented

□ Other (specify):

* 1. When was the visit scheduled to take place?

□ 3 months

□ 6 months

□ 1 year

□ Unknown/Not documented

1. If routine postpartum care was not received as recommended by ACOG, were there any specific barriers to receiving prenatal care?

□ Lack of finances

□ Limitations due to health insurance coverage

□ Lack of transportation

□ No mobile device

□ No access to a provider

□ Lack of childcare

□ Language barriers

□ Distrust of the healthcare system

□ Other *(specify)*:

1. Did the postpartum person receive an evidence-based visitor or other type of case management during a postpartum care appointment in the 6- weeks post-partum period?

□ Yes

□ No

Additional comments: Please note any additional/clarifying comments related to the mother or birthing person’s post-partum care.

|  |
| --- |
| **Pregnancy Intention** |

1. Was there a discussion about future pregnancy intention documented in the chart?

□ Yes, future pregnancy planned

□ Yes, future pregnancy not intended *(skip to #18)*

□ No (*skip to #19*)

* 1. If a future pregnancy is planned, was timing of the next pregnancy discussed?

□ Yes

□ No

□ Unknown/Undocumented

1. Which health care provider(s) discussed her future pregnancy intentions? (*check all that apply*)

□ Nurse Practitioner

□ Nurse Midwife

□ Family Physician

□ Obstetrician or Gynecologist

□ Internists

□ Perinatologist

□ HIV Specialist (e.g. Infectious Disease Specialist)

□ Physician Assistant

□ Unknown/Not documented

□ Other *(specify)*:

1. Indicate all family planning methods the mother or birthing person was using and/or prescribed or recommended. *(check all that apply)*

□ Record does not indicate if contraception is being used or prescribed

|  |  |  |  |
| --- | --- | --- | --- |
| **Method** | **Using** | **Prescribed or Recommended** | **Comments** |
| Abstinence | □ Yes | □ Yes |  |
| **Traditional Methods** | | | |
| Withdrawal | □ Yes | □ Yes |  |
| Fertility Awareness Method (FAM) | □ Yes | □ Yes |  |
| Lactational Amenorrhea Method (LAM) | □ Yes | □ Yes |  |
| **Barrier Methods** | | | |
| Male Condom | □ Yes | □ Yes |  |
| Female Condom | □ Yes | □ Yes |  |
| Diaphragm | □ Yes | □ Yes |  |
| Cervical Cap | □ Yes | □ Yes |  |
| Contraceptive Sponge | □ Yes | □ Yes |  |
| **Hormonal Methods** | | | |
| Hormonal Intrauterine Device (IUD) | □ Yes | □ Yes |  |
| Implant (Implanon) | □ Yes | □ Yes |  |
| Patch (OrthoEvra) | □ Yes | □ Yes |  |
| Injection (Depo-Provera) | □ Yes | □ Yes |  |
| Vaginal Ring (NuvaRing) | □ Yes | □ Yes |  |
| Oral Contraceptive (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes | □ Yes |  |
| Emergency Contraception | □ Yes | □ Yes |  |
| **Non-Hormonal Methods** | | | |
| Non-hormonal Intrauterine Device (IUD) | □ Yes | □ Yes |  |
| Male Sterilization | □ Yes | □ Yes |  |
| **Other** | | | |
| Specify:\_\_\_\_\_\_\_\_\_ | □ Yes | □ Yes |  |
| **Sterilization** | **Performed at L&D** | **Scheduled for:** | **Comments** |
| Female tubal ligation | □ Yes | \_\_/\_\_/\_\_\_\_ |  |
| Female hysterectomy | □ Yes | \_\_ /\_\_/\_\_\_\_ |  |

Additional comments: Please note any additional/clarifying comments related to the mother or birthing person’s pregnancy intention.

|  |
| --- |
| **HIV Care** |

1. Was there documentation of a previously established diagnosis of HIV infection?

□ Yes

□ No

1. Documented HIV testing during the post-partum period:

□ No testing documented (*skip to # 22*)

|  |  |  |  |
| --- | --- | --- | --- |
| Date testing offered | Type of test or refusal | Test Result | Date communicated to patient |
| \_\_/\_\_/\_\_\_\_ | □ Testing refused  □ HIV-1/2 antigen/antibody immunoassay  □ HIV-1 EIA  □ HIV-1/2 EIA or IA  □ HIV-1 Western blot  □ HIV-2 Western blot  □ HIV-1 Immunofluorescence Assay (IFA)  □ HIV-1 Rapid Test  □ HIV-1/2 Rapid Test  □ Multispot HIV-1/HIV-2 (differentiation) Rapid Test  □ HIV-1 bDNA Viral load PCR or NAT or NAAT  □ HIV-1 RNA Viral load PCR or NAT or NAAT  □ Aptima HIV-1 RNA Qualitative Assay | Positive  Negative Intermediate |  |
|  |  |  |  |

1. Were CD4 counts obtained?

□ Yes

□ No *(skip to #23)*

□ Unknown/Not documented *(skip to #23)*

* 1. If yes, list below (if more than four in record, prioritize the most recent CD4 counts).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CD4 Results** | **Units** | **Date of Test** | **CD4 Results** | **Units** | **Date of Test** |
| \_\_ \_\_ \_\_ \_\_ | Count | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_ \_\_ \_\_ \_\_ | Count | \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| \_\_ \_\_ \_\_ \_\_% | Percent | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_ \_\_ \_\_ \_\_% | Percent | \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| \_\_ \_\_ \_\_ \_\_ | Count | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_ \_\_ \_\_ \_\_ | Count | \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| \_\_ \_\_ \_\_ \_\_% | Percent | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_ \_\_ \_\_ \_\_% | Percent | \_\_\_\_/\_\_\_\_/\_\_\_\_ |

1. Did the mother or birthing person have viral quantification tests performed (i.e. viral load)?

□ Yes

□ No (*skip to # 24*)

□ Unknown/Not documented *(skip to #24)*

* 1. If yes, list below (if more than three in record, prioritize the most recent viral load tests).

|  |  |  |
| --- | --- | --- |
| **Result in copies/mL #** | **Result in logs** | **Date Blood Drawn** |
| □ Undetectable  Level of detection: \_\_\_ \_\_\_ \_\_\_  \_\_\_, \_\_\_ \_\_\_ \_\_\_, \_\_\_ \_\_\_ \_\_\_ |  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| □ Undetectable  Level of detection: \_\_\_ \_\_\_ \_\_\_  \_\_\_, \_\_\_ \_\_\_ \_\_\_, \_\_\_ \_\_\_ \_\_\_ |  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| □ Undetectable  Level of detection: \_\_\_ \_\_\_ \_\_\_  \_\_\_, \_\_\_ \_\_\_ \_\_\_, \_\_\_ \_\_\_ \_\_\_ |  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |

1. Was the mother or birthing person taking or prescribed any antiretroviral medication?

□ Yes

□ No (*Skip to #24b*)

□ Unknown/Undocumented *(skip to #25)*

* 1. If yes, list below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug Name** | **Date started** | **Drug Stopped?** | **Reason Drug Stopped** |
| I. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| II. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| III. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| IV. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| V. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |

* 1. If no ARVs were continued or prescribed, indicate why not *(check all that apply)*:

□ HIV status of mother or birthing person unknown

□ All ARVs were refused

□ Treatment not indicated

□ Other *(specify)*:

□ Unknown/Not documented

1. Please list all antiretroviral resistance testing performed:

□ No documentation of ARV resistance testing performed during post-pregnancy period.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Test | Date of Test | Clinician notes about results |
| ARV resistance test #1 | □ Genotypic  □ Phenotypic | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ARV resistance test #2 | □ Genotypic  □ Phenotypic | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Additional comments: Please note any additional/clarifying comments related to mother or birthing person’s HIV testing and care.

|  |
| --- |
| **Follow up of Pre-existing Conditions Comorbidities, Health Risk Factors, OIs and AIDS Defining Illnesses** |

1. List the discharge diagnoses from the labor and delivery record (generated by data system or see Delivery Hospitalization Record).

|  |  |  |
| --- | --- | --- |
| Diagnoses | Follow-up Documented | Comments |
|  | □ Yes □ No |  |
|  | □ Yes □ No |  |
|  | □ Yes □ No |  |
|  | □ Yes □ No |  |
|  | □ Yes □ No |  |

1. Is there evidence of the following comorbidities or health risk factors? (*Check all that apply*).

□ No evidence of preconception health risk factors

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Risk Factor** | **Assessed** | | **New Diagnosis** | **Long Standing Diagnosis** | **Intervention or referral done** | **Comments** |
| **Cardiovascular Disease** | | | | | | |
| Bacterial Endocarditis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Arrhythmia | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Congestive heart failure | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| DVT (deep vein thrombosis) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| MVP (mitral valve prolapse) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| PE (pulmonary embolism) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hypertension | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Urologic Disease** | | | | | | |
| Cystitis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Acute Pyelonephritis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Renal Disease | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Endocrinologic/Metabolic** | | | | | | |
| Thyroid (specify in comments) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Diabetes (specify class in comments) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hyperglycemia | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Adrenal: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Pituitary: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Respiratory Disease** | | | | | | |
| Active Tuberculosis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Latent Tuberculosis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Asthma | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Pneumonia | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Neuro/psychiatric** | | | | | | |
| Psychiatric illness (specify in comments) | | □ Yes | □ Yes | □ Yes | □ Yes |  |
| Seizure disorder | | □ Yes | □ Yes | □ Yes | □ Yes |  |
| Hx of perinatal-related depression | | □ Yes | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | | □ Yes | □ Yes | □ Yes | □ Yes |  |
| **Hematologic** | | | | | | |
| Folic acid deficiency | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Rh Sensitized | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hemolytic anemia | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Iron deficiency anemia | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Sickle cell disease | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Gastrointestinal/Hepatic** | | | | | | |
| Cirrhosis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hepatitis A | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hepatitis B | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hepatitis C | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Hepatoxicity | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Pancreatitis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Cholecystitis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Ulcer: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Inflammatory Bowel Disease | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Trauma/physical injury** | | | | | | |
| Specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Immunologic** | | | | | | |
| Red Blood Cell Antibody Screen | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| ITP/TTP | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Arthritis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Systemic lupus erythematosus | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **STIs** | | | | | | |
| Pap Test | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Chlamydia trachomatis | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Neisseria gonorrhoeae | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Condylomata acuminata (genital warts) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Herpes simplex virus | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Treponema pallidum (Syphilis) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Trichomonas | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Human Papillomavirus (specify in comments) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Infectious Diseases** | | | | | | |
| HIV/AIDS | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Rubella susceptibility | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| SARS-CoV-2 (COVID-19) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Influenza | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Varicella | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Group B strep | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Substance Use (Based on screening or self-report** | | | | | | |
| Toxicology Screen | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Alcohol | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Nicotine/tobacco | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Crack | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Cocaine | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Crystal meth (methamphetamine) | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Heroin | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Opiates | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Marijuana or hashish | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| PCP, angel dust, LSD | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Speed/uppers | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Methadone | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Drug use but unknown type | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| **Were any of the above substances injected?** □ No □ Yes (specify in comments) □ Unknown | | | | | | |
| **Other Risk Factors** | | | | | | |
| Obesity | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Isotretinoins | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Oral anticoagulant | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Anti-epileptic drugs | □ Yes | | □ Yes | □ Yes | □ Yes |  |
| Other maternal health condition (specify in comments) | □ Yes | | □ Yes | □ Yes | □ Yes |  |

1. Is there evidence of the following opportunistic infections or AIDS defining illnesses?

□ Opportunistic infections/AIDS defining illnesses not documented

|  |  |  |  |
| --- | --- | --- | --- |
| **Opportunistic Infections and AIDS Defining Illnesses** | **Diagnosis Prior to Pregnancy?** | **After this pregnancy?** | **Comments** |
| Candidiasis, bronchi, trachea, or lungs | □ Yes | □ Yes |  |
| Candidiasis, esophageal | □ Yes | □ Yes |  |
| Carcinoma, invasive cervical | □ Yes | □ Yes |  |
| Coccidioidomycosis, dissem. or extrapulmonary | □ Yes | □ Yes |  |
| Cryptococcosis, extrapulmonary | □ Yes | □ Yes |  |
| Cryptosporidiosis, chronic intestinal | □ Yes | □ Yes |  |
| Cytomegalovirus retinitis | □ Yes | □ Yes |  |
| Cytomegalovirus disease, other | □ Yes | □ Yes |  |
| HIV encephalopathy | □ Yes | □ Yes |  |
| Herpes simplex genital or oral | □ Yes | □ Yes |  |
| Histoplasmosis, dissem.or extrapulmonary | □ Yes | □ Yes |  |
| Cystoisosporiasis, chronic intestinal | □ Yes | □ Yes |  |
| Kaposi's sarcoma | □ Yes | □ Yes |  |
| Lymphoma, Burkitt's | □ Yes | □ Yes |  |
| Lymphoma, immunoblastic | □ Yes | □ Yes |  |
| Lymphoma, primary in brain | □ Yes | □ Yes |  |
| Mycobacterium avium complex | □ Yes | □ Yes |  |
| M. tuberculosis, pulmonary | □ Yes | □ Yes |  |
| Mycobacterium, dissem.or extrapulmonary | □ Yes | □ Yes |  |
| M. tuberculosis, dissem.or extrapulmonary | □ Yes | □ Yes |  |
| Pneumocystis jirovecii | □ Yes | □ Yes |  |
| Pneumonia, recurrent | □ Yes | □ Yes |  |
| Progressive multifocal leukoencephalopathy | □ Yes | □ Yes |  |
| Salmonella septicemia | □ Yes | □ Yes |  |
| Toxoplasmosis of brain | □ Yes | □ Yes |  |
| Wasting syndrome due to HIV | □ Yes | □ Yes |  |
| HIV-related dementia | □ Yes | □ Yes |  |

Additional comments: Please note any additional/clarifying comments related to mother or birthing person’s comorbidities, OIs, AIDS defining illnesses, substance abuse and other health risk factors.

|  |
| --- |
| **Hospitalization and Emergency Department Visits** |

1. List the hospital visits or emergency department visits.

□ There were no hospital or emergency visits (*skip to #30*).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Visit | Date of Admission | Date of discharge | Type of hospital visit | Admission diagnosis | Discharge Diagnoses | HIV status was documented? | Treatment |
| 1 | / / | / / | □ ED Only  □ Hospital Admission |  |  | □ Yes |  |
| 2 | / / | / / | □ ED Only  □ Hospital Admission |  |  | □ Yes |  |
| 3 | / / | / / | □ ED Only  □ Hospital Admission |  |  | □ Yes |  |

* 1. Is there documentation that the mother or birthing person was subsequently referred to another provider?

□ Yes *(specify for what diagnosis and to whom)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No

* 1. List Significant Outcomes of hospitalizations and/or ER visits:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional comments: Please note any additional/clarifying comments related to the mother or birthing person’s hospitalization and emergency room visits.

|  |
| --- |
| **Overall Health Education** |

1. At any time were any of the following topics documented as having been discussed?

□ There were none documented

|  |  |  |
| --- | --- | --- |
| **Topic** | **Discussed** | **Comments** |
| Transmitting HIV or STDs | □ Yes |  |
| Medicines to help protect the baby from getting HIV | □ Yes |  |
| Importance of HIV medicines | □ Yes |  |
| HIV medicines the baby should receive | □ Yes |  |
| Medication adherence | □ Yes |  |
| CD4 and viral load tests | □ Yes |  |
| Pregnancy Interval | □ Yes |  |
| Finding a doctor or nurse practitioner to care for the baby | □ Yes |  |
| How smoking could affect the baby | □ Yes |  |
| Depression | □ Yes |  |
| How long to wait before having another baby (child spacing) | □ Yes |  |
| Intimate Partner Violence | □ Yes |  |
| Breast care | □ Yes |  |
| Safe sleep/SIDS risk reduction activities | □ Yes |  |
| Safe infant feeding/Lactation Suppression | □ Yes |  |
| Partner counseling and referral services | □ Yes |  |
| Signs/Symptoms that warrant medical attention | □ Yes |  |
| Nutrition for the childbearing parent | □ Yes |  |
| Physical activity/exercise | □ Yes |  |
| Vaccinations | □ Yes |  |
| Other Topics Documented (specify)  ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes |  |

Additional comments: Please note any additional/clarifying comments related to health education the mother or birthing person received.

|  |
| --- |
| **Stressors, Violence, Mental Health, Social Support & Case Management** |

1. Was there documentation that a social worker or case manager saw the mother?

□ Yes

□ No (Skip to #33)

□ Unknown/Undocumented (Skip to #33)

1. Did medical, nursing or social work personnel identify any of the problems listed below? (check all that apply) Indicate whether a case management plan was developed for identified problems.

□ Chart does not indicate a problem (*skip to #33*).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem** | **Documented during 6-week postpartum period** | **Documented after 6-week postpartum period** | **Case management plan developed or in place?** | **Was this a Ryan White case management resource?** |
| Disturbed relationship with other child/children | □ | □ | □ | □ Yes |
| Depression | □ | □ | □ | □ Yes |
| Inadequate support systems | □ | □ | □ | □ Yes |
| Housing inadequate/homeless | □ | □ | □ | □ Yes |
| Need for Public Assistance, Medicaid, Food Stamps, WIC, or other financial support | □ | □ | □ | □ Yes |
| Physical assault by any partner | □ | □ | □ | □ Yes |
| Threats, restriction of movement or contacting other people by any partner | □ | □ | □ | □ Yes |
| Forced sex | □ | □ | □ | □ Yes |
| Substance abuse | □ | □ | □ | □ Yes |
| Mother abused as child | □ | □ | □ | □ Yes |
| Drug/EtOH abuse (mother/partner) | □ | □ | □ | □ Yes |
| Employment/education needs (mother/partner) | □ | □ | □ | □ Yes |
| Crime/legal problems (mother/partner) | □ | □ | □ | □ Yes |
| Lack of transportation | □ | □ | □ | □ Yes |
| Other *(specify)*: | □ | □ | □ | □ Yes |

* 1. What ***treatments*** were documented for these problems?

1

2

3

4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ None

□ Unknown/Not documented

1. Is there documentation of referral(s) for any support services during the postpartum care?

(Check all that apply)

□ No referrals for support services were documented in the post pregnancy period

|  |  |
| --- | --- |
| **Referral Type** |  |
| □ Financial Planning |  |
| □ WIC |  |
| □ Food Stamps |  |
| □ Housing Authority |  |
| □ Shelter Services |  |
| □ Smoking Cessation Program |  |
| □ Alcohol treatment program |  |
| □ AIDS Drug Assistance Program |  |
| □ Methadone Maintenance Program |  |
| □ Other Drug Treatment Program |  |
| □ Medicaid |  |
| □ Unemployment Office |  |
| □ GED programs |  |
| □ Legal aid |  |
| □ Physically handicapped child program |  |
| □ Infant/child health program |  |
| □ Home technology (i.e., photo therapy, etc.) |  |
| □ Partner services |  |
| □ Child Protective Services |  |
|  | **Was this a Ryan White resource?** |
| □ Evidence-based home visiting program | □ Yes  □ No  □ Unknown/Not documented |
| □ Homemaker/Home health aide | □ Yes  □ No  □ Unknown/Not documented |
| □ Mental Health Services | □ Yes  □ No  □ Unknown/Not documented |
| □ Clinical Case Management (e.g. Healthy Start) | □ Yes  □ No  □ Unknown/Not documented |
| □ Ongoing Social Work Case Management | □ Yes  □ No  □ Unknown/Not documented |
| □ Family Planning | □ Yes  □ No  □ Unknown/Not documented |
| □ Other (*specify*): | □ Yes  □ No  □ Unknown/Not documented |

Additional comments: Please note any additional/clarifying comments related to stressors, violence, mental health, social support and case management.

|  |
| --- |
| **Additional Comments** |

Use this space to record any other information that might be of interest for this review.

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