**Prior-to-Pregnancy HIV Care**

|  |
| --- |
| Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Abstraction Completion Date: \_\_\_/\_\_\_/\_\_\_ LMP Date : \_\_\_/\_\_\_/\_\_\_ |

1. This form collects information relating to the health care the mother or birthing person received *during the year prior* to this pregnancy. Please indicate the sources used to complete this form (check all that apply):

□ HIV Care Record

□ Prenatal Care Record

□ Hospitalization Record

□ Case Management Record

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

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

\*\*Please confirm that information entered in this form occurred during the year prior to this pregnancy starting from the last menstrual period (LMP) date.\*\*

**Introductory Information**

1. What was the payor source for HIV care prior to this pregnancy? *(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

□ CHAMPUS/Military insurance

□ Ryan White

□ Self pay, but eligible for Medicaid

□ Self pay

□ Other *(specify)*:

1. For each type of care, indicate where the services were received and the provider type prior to this pregnancy *(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 | □ | □ | □ | □ |  |
| Internal Medicine/Family Practice | □ | □ | □ | □ |  |
| Adult HIV specialty care center | □ | □ | □ | □ |  |
| County/Local Health Department | □ | □ | □ | □ |  |
| Managed Care Organization (MCO) or Health Maintenance Organization (HMO) | □ | □ | □ | □ |  |
| Community Health Center | □ | □ | □ | □ |  |
| School or Work-based clinic | □ | □ | □ | □ |  |
| Correctional facility | □ | □ | □ | □ |  |
| Clinic in a hospital | □ | □ | □ | □ |  |
| Indian health services/ Tribal/Urban | □ | □ | □ | □ |  |
| None documented | □ | □ | □ | □ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |
| **Provider Type** |
| Nurse Practitioner | □ | □ | □ | □ |  |
| Nurse Midwife | □ | □ | □ | □ |  |
| Family Physician | □ | □ | □ | □ |  |
| Obstetrician or Gynecologist | □ | □ | □ | □ |  |
| Internist | □ | □ | □ | □ |  |
| Perinatologist | □ | □ | □ | □ |  |
| HIV Specialist (e.g., Infectious Disease Specialist) | □ | □ | □ | □ |  |
| Physician Assistant | □ | □ | □ | □ |  |
| Unknown/Not documented | □ | □ | □ | □ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ |  |

Additional comments: Please note any additional/clarifying comments for introductory information.

**HIV Testing**

1. Was there documentation of an established HIV diagnosis prior to pregnancy?

□ Yes

□ No

1. List any documented HIV testing during the year prior to this pregnancy:

 □ No testing documented (skip to #7)

|  |  |  |  |
| --- | --- | --- | --- |
| Date testing offered | Type of test or refusal | Test Result | Date communicated to patient |
|  |  |  |  |
|  |  |  |  |

1. Indicate the type of provider making the diagnosis and the location of the diagnosis.

|  |  |
| --- | --- |
| **Type of Provider** | **Location of Diagnosis** |
| □ Nurse Practitioner | □ Private Provider’s office |
| □ Nurse Midwife | □ County or City Health Department *(specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Family Physician/Internist | □ Managed Care Organization |
| □ Obstetrician | □ Clinic in a hospital |
| □ Internist | □ Hospital emergency room, other episodic/as needed care provider |
| □ Perinatologist | □ Community Health Center |
| □ HIV Specialist (e.g., ID Specialist) | □ Indian Health Services/Tribal/Urban |
| □ Physician Assistant | □ Other *(specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Other *(specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Unknown/Not Documented |
| □ Unknown/Not Documented |  |

Additional comments: Please note any additional/clarifying comments related to HIV testing prior to this pregnancy.

**HIV Care Prior to Pregnancy**

1. Is there documentation of HIV care *during the year prior to this pregnancy*?

□ Yes

□ No *(skip to #14)*

1. Was the mother or birthing person prescribed any antiretroviral medication *during the year prior to this pregnancy*?

□ Yes *(complete table)*

□ No (skip to #9)

□ Unknown *(skip to #9)*

|  |  |  |  |
| --- | --- | --- | --- |
| Drug Name | Date Drug Started in the year prior to pregnancy | Drug stopped in the year prior to pregnancy | Reason Drug Stopped |
| I. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| II. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| III. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| IV. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| V. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| VI. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| VII. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |
| VIII. | \_\_\_\_/\_\_\_\_/\_\_\_\_ | □ Yes |  |

1. If no ARVs were prescribed *during the year* *prior to this pregnancy* indicate reason *(check all that apply)*:

□ Mother or birthing person did not receive HIV care prior to pregnancy

□ HIV serostatus of mother or birthing person unknown

□ Mother or birthing person known to be HIV negative during this time period

□ All ARVs were refused

□ Treatment not indicated

□ Other *(specify)*:

□ Unknown/Not documented

1. Were CD4 counts obtained in the year *prior to this pregnancy*?

□ Yes

□ No *(skip to #12)*

□ Unknown/Not documented *(skip to #12)*

1. If yes, list below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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) in the year *prior to this pregnancy*?

□ Yes

□ No *(skip to #13)*

□ Unknown/Not documented *(skip to #13)*

* 1. If yes, list below (if more than three in record, prioritize those viral load tests closest to conception).

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

1. Please list all antiretroviral resistance testing performed:

□ Unknown/Not documented

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 HIV care prior to this pregnancy.

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

**Preconception Health Risk Factors Prior to Pregnancy**

1. Is there evidence of the following preconception health risk factors? Check all that apply.

□ No evidence of preconception health risk factors.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Risk Factor** | **Assessed** | **Known Prior to Current Pregnancy** | **Intervention or referral done** | **Comments** |
| **Cardiovascular Disease** |
| Bacterial Endocarditis | □ Yes | □ Yes | □ Yes |  |
| Arryhthmia | □ Yes | □ Yes | □ Yes |  |
| Congestive heart failure | □ Yes | □ Yes | □ Yes |  |
| DVT (deep vein thrombosis) | □ Yes | □ Yes | □ Yes |  |
| MVP (mitral valve prolapse) | □ Yes | □ Yes | □ Yes |  |
| PE (pulmonary embolism) | □ Yes | □ Yes | □ Yes |  |
| Hypertension | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Urologic Disease** |
| Cystitis | □ Yes | □ Yes | □ Yes |  |
| Acute Pyelonephritis | □ Yes | □ Yes | □ Yes |  |
| Renal Disease | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Endocrinologic/Metabolic** |
| Thyroid (specify in comments) | □ Yes | □ Yes | □ Yes |  |
| Diabetes (specify class in comments) | □ Yes | □ Yes | □ Yes |  |
| Hyperglycemia | □ Yes | □ Yes | □ Yes |  |
| Adrenal: specify in comments | □ Yes | □ Yes | □ Yes |  |
| Pituitary: specify in comments | □ Yes | □ Yes | □ Yes |  |
| Maternal phenylketonurea (PKU) | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Respiratory Disease** |
| Active Tuberculosis | □ Yes | □ Yes | □ Yes |  |
| Asthma | □ Yes | □ Yes | □ Yes |  |
| Pneumococcal infection | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Neuro/psychiatric** |
| Attention Deficit/Hyperactivity Disorder | □ Yes | □ Yes | □ Yes |  |
| Anxiety  | □ Yes | □ Yes | □ Yes |  |
| Major Depressive Disorder  | □ Yes | □ Yes | □ Yes |  |
| Schizophrenia | □ Yes | □ Yes | □ Yes |  |
| Bipolar Affective Disorder | □ Yes | □ Yes | □ Yes |  |
| Post-traumatic Stress Disorder  | □ Yes | □ Yes | □ Yes |  |
| Eating Disorder | □ Yes | □ Yes | □ Yes |  |
| Obsessive-Compulsive Disorder  | □ Yes | □ Yes | □ Yes |  |
| Psychiatric illness (specify) | □ Yes | □ Yes | □ Yes |  |
| Seizure disorder | □ Yes | □ Yes | □ Yes |  |
| Hx of perinatal related depression | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Hematologic** |
| Folic acid deficiency | □ Yes | □ Yes | □ Yes |  |
| Rh Sensitized | □ Yes | □ Yes | □ Yes |  |
| Hemolytic anemia | □ Yes | □ Yes | □ Yes |  |
| Iron deficiency anemia | □ Yes | □ Yes | □ Yes |  |
| Sickle cell disease | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Hepatic** |
| Cirrhosis | □ Yes | □ Yes | □ Yes |  |
| Hepatitis A | □ Yes | □ Yes | □ Yes |  |
| Hepatitis B | □ Yes | □ Yes | □ Yes |  |
| Hepatitis C | □ Yes | □ Yes | □ Yes |  |
| Hepatoxicity | □ Yes | □ Yes | □ Yes |  |
| Pancreatitis | □ Yes | □ Yes | □ Yes |  |
| Cholecystitis | □ Yes | □ Yes | □ Yes |  |
| Ulcer: specify in comments | □ Yes | □ Yes | □ Yes |  |
| Inflammatory Bowel Disease | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Trauma/physical injury** |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Immunologic** |
| Atypical Antibody Screen  | □ Yes | □ Yes | □ Yes |  |
| ITP/TTP | □ Yes | □ Yes | □ Yes |  |
| Arthritis | □ Yes | □ Yes | □ Yes |  |
| Systemic lupus erythematosus | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **STIs** |
| Pap test | □ Yes | □ Yes | □ Yes |  |
| Chlamydia trachomatis | □ Yes | □ Yes | □ Yes |  |
| Neisseria gonorrhoeae | □ Yes | □ Yes | □ Yes |  |
| Condylomata acuminata (genital warts) | □ Yes | □ Yes | □ Yes |  |
| Herpes simplex virus | □ Yes | □ Yes | □ Yes |  |
| Treponema pallidum (syphilis) | □ Yes | □ Yes | □ Yes |  |
| Trichomonas | □ Yes | □ Yes | □ Yes |  |
| Human Papillomavirus (specify in comments) | □ Yes | □ Yes | □ Yes |  |
| Other STI (specify) | □ Yes | □ Yes | □ Yes |  |
|  **Infectious Diseases** |
| COVID-19 | □ Yes | □ Yes | □ Yes |  |
| HIV/AIDS | □ Yes | □ Yes | □ Yes |  |
| Rubella susceptibility | □ Yes | □ Yes | □ Yes |  |
| Influenza | □ Yes | □ Yes | □ Yes |  |
| Varicella | □ Yes | □ Yes | □ Yes |  |
| Group B strep | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Substance Abuse** |
| Toxicology screen | □ Yes | □ Yes | □ Yes |  |
| Alcohol use | □ Yes | □ Yes | □ Yes |  |
| Nicotine/tobacco | □ Yes | □ Yes | □ Yes |  |
| Crack | □ Yes | □ Yes | □ Yes |  |
| Cocaine | □ Yes | □ Yes | □ Yes |  |
| Crystal meth (methamphetamine) | □ Yes | □ Yes | □ Yes |  |
| Heroin | □ Yes | □ Yes | □ Yes |  |
| Fentanyl  | □ Yes | □ Yes | □ Yes |  |
| Opiates | □ Yes | □ Yes | □ Yes |  |
| Marijuana or hashish | □ Yes | □ Yes | □ Yes |  |
| PCP, angel dust, LSD | □ Yes | □ Yes | □ Yes |  |
| Speed/uppers | □ Yes | □ Yes | □ Yes |  |
| Methadone | □ Yes | □ Yes | □ Yes |  |
| Drug use but unknown type | □ Yes | □ Yes | □ Yes |  |
| Other: specify in comments | □ Yes | □ Yes | □ Yes |  |
| **Were any of the above substances injected?** □ No □ Yes (specify in comments column) □ Unknown  |
| **Other Risk Factors** |
| Anti-epileptic drugs | □ Yes | □ Yes | □ Yes |  |
| Obesity | □ Yes | □ Yes | □ Yes |  |
| Oral anticoagulant | □ Yes | □ Yes | □ Yes |  |
| Isotretinoins | □ Yes | □ Yes | □ Yes |  |
| Other maternal health condition (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes | □ Yes | □ Yes |  |

1. Please list any medications noted in the records that the mother or birthing person was taking during in the year prior to pregnancy. Do not include ARVs.

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

Additional comments: Please note any additional/clarifying comments related to additional preconception care, health risk factors and family planning used prior to this pregnancy.

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

|  |
| --- |
| **Preconception Care and Family Planning** |

1. Is there documentation that the mother or birthing person received specific preconception counseling before she became pregnant?

□ Yes

□ No

18) Indicate all family planning methods the mother or birthing person was using and/or prescribed or recommended in the year prior to pregnancy. *(check all that apply)*

□ Chart does not indicate if contraception was used prior to pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |  | **Scheduled for:** | **Comments** |
| Female tubal ligation | □ Yes | \_\_/\_\_/\_\_\_\_ |  |
| Female hysterectomy  | □ Yes | \_\_ /\_\_/\_\_\_\_ |  |

Additional comments: Please note any additional/clarifying comments related to additional preconception care, health risk factors and family planning used prior to this pregnancy.

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

**Opportunistic Infections and AIDS defining illness**

1. Does the mother or birthing person have a documented history of any of the following opportunistic illnesses?

□ No documented history of opportunistic infections.

|  |  |  |  |
| --- | --- | --- | --- |
| **Opportunistic Infections** | **Ever prior to this pregnancy?** | **Was this within a year prior to 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 |  |
| Isosporiasis, 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 jiroveci | □ 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 OIs and AIDS defining illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

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

1. List hospital visits or emergency department visits *during the year prior to pregnancy****.***

□ No documented hospital or emergency department visits during the year prior to pregnancy (*skip to 22*).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 □ No |  |
| 2 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 3 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 4 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 5 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 6 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 7 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 8 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 9 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |
| 10 | / / | / / | □ ED Only□ Hospital Admission |  |  | □ Yes □ No |  |

*\*\*If there are more visits than able to fit on the table, please attach an additional document listing the visit information.*

 20a) 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 emergency department visits:

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

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

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

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

**Stressors, Violence, Social Support & Case Management Prior to this Pregnancy**

1. Was there documentation that a social worker or case manager saw the mother or birthing person in the year prior to this pregnancy?

□ Yes

□ No

□ Unknown/Undocumented

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

□ No problems identified in the year prior to pregnancy (*skip to 22c*).

|  |  |  |  |
| --- | --- | --- | --- |
| **Problem** | **Documented prior to this pregnancy** | **Case management plan developed** | **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 or birthing person abused as child | □ | □ | □ Yes |
| Drug/EtOH abuse (mother or birthing person/partner) | □ | □ | □ Yes |
| Employment/education needs (mother or birthing person/partner) | □ | □ | □ Yes |
| Crime/legal problems (mother or birthing person/partner) | □ | □ | □ Yes |
| Lack of transportation | □ | □ | □ Yes |
| Teen mother | □ |  |  |
| Single mother | □ |  |  |
| 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 in the year prior to pregnancy? (Check all that apply)

□ No referrals for support services were documented in the year prior to pregnancy

|  |  |
| --- | --- |
| **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 |  |
| □ Genetic evaluation counseling |  |
| □ Medicaid |  |
| □ Unemployment Office |  |
| □ Child Protective Services |  |
| □ GED programs |  |
| □ Legal aid |  |
| □ Physically handicapped child program |  |
| □ Infant/child health program  |  |
| □ Home technology (ie photo therapy, etc.) |  |
| □ Partner 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, social support, case management, etc. prior to this pregnancy.

|  |
| --- |
| Additional Comments |

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

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