

PRTII Preliminary Positive Data Collection Form

1. **Immediately call** the 24-hour IL Perinatal HIV Hotline at (800) 439-4079 **to report all** preliminary positive rapid test results.
2. Complete reporting institution information box **for all calls**.
3. Complete the delivery and treatment information box for **all** positive rapid test results.
4. Complete the patient information box **only** if a release of information is signed by the patient. If release is signed, PACPI will assist with case management and follow-up at your request.

Staff filling out form: _____	Staff phone number _____
Delivery Hospital/City: _____	Date of Delivery: ____/____/____ Time of Delivery ____:____
Maternal age: _____	Maternal race _____ G ____ P _____
Prenatal Care: <input type="checkbox"/> None <input type="checkbox"/> Sporadic <input type="checkbox"/> Routine	
Type: <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Private Office <input type="checkbox"/> Health Dept Clinic	
In the opinion of the staff, did the patient know her HIV positive status (even before the rapid test was performed) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was a DCFS referral made for this family? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Complete the following (including dates and times) for *all* patients with a preliminary positive rapid test.

	Date (MM/DD/YYYY)	Time (24 hour clock)
1. Presentation at L & D	/ /	:
2. Reason for undocumented HIV status <input type="checkbox"/> No PNC <input type="checkbox"/> No PNC record available <input type="checkbox"/> Not tested antenatally (not offered / declined)		
3. Date/Time maternal sample obtained for rapid test	/ /	:
Test Brand used: <input type="checkbox"/> Oraquick <input type="checkbox"/> Unigold <input type="checkbox"/> Reveal <input type="checkbox"/> Multispot <input type="checkbox"/> Other		
Rapid Test performed at: <input type="checkbox"/> POC/L&D <input type="checkbox"/> Lab		
4. Date/Time Maternal rapid test result available	/ /	:
5. Date/Time Baby sample for rapid test obtained (if applicable)	/ /	:
6. Date/Time Baby rapid test result available (if applicable)	/ /	:
7. Reason mom not rapid tested: <input type="checkbox"/> offered, declined <input type="checkbox"/> not offered, not tested <input type="checkbox"/> offered, accepted but delivered before test could be done <input type="checkbox"/> other		
8. Maternal Treatment before Delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date/Time AZT IV started	/ /	:
Date/Time AZT PO started	/ /	:
Other medication started (specify: _____)	/ /	:
9. Route of Delivery		
<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> Non-Emergent / Scheduled Cesarean <input type="checkbox"/> Emergent Cesarean <input type="checkbox"/> Unknown		
10. Newborn Treatment:		
Date/Time AZT syrup started (Was it within 12 hours of birth? <input type="checkbox"/> Yes <input type="checkbox"/> No)	/ /	:
Date/Time Nevirapine PO started	/ /	:
Other (specify: _____)	/ /	:
Pediatrician/Obstetrician of record is responsible for the following six items:		
11. Date/Time patient informed of rapid test results	/ /	:
12. Infant d/c with \geq 7 days AZT syrup <input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	:
13. Newborn HIV care referral made to (place): _____	/ /	:
14. Mother HIV care referral made to (place): _____	/ /	:
15. IL Perinatal HIV Hotline called: (800) 439-4079 (required by IDPH rules)	/ /	:
16. Local Dept Public Health called (if applicable)	/ /	:
Follow up: Please complete and re-fax form to PACPI when follow up information is available.		
17. Confirmatory Western Blot test sent:		
Result: <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> indeterminate	/ /	:
18. Patient informed of Western Blot result <input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	:
19. Infant HIV-DNA PCR sent: <input type="checkbox"/> Yes <input type="checkbox"/> No Result: <input type="checkbox"/> positive <input type="checkbox"/> negative	/ /	:

Patient's name: _____

Medical record #: _____

Address: _____

Home Telephone #: () _____ - _____

Patient's date of birth ___/___/___

Emergency Contact info: _____

Please send this form to (PACPI): Fax (312) 334-0973. For questions, call (312) 334-0974 or email PACPI2000@aol.com