**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 screen results.

2. Complete reporting institution information box **for all calls and send immediately to 312-334-0973 or** [**anne@pacpi.org**](mailto:anne@pacpi.org)

3. Complete the delivery and treatment information box for **all** positive rapid screen results. Send immediately and resend after supplemental results are available (questions 17-18).

Staff filling out form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Delivery: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Time of Delivery \_\_\_\_:\_\_\_\_

Maternal age: \_\_\_\_\_\_ Maternal race \_\_\_\_\_\_\_\_\_\_\_\_\_\_ G \_\_\_\_ P \_\_\_\_\_\_\_ Gestational Age \_\_\_\_\_\_ (wks) at time of test

Prenatal Care: 🞏 None 🞏 Sporadic 🞏 Routine Type: 🞏 Hospital Clinic 🞏 Private office 🞏 Health Dept Clinic

In the opinion of staff, did the patient actually know her HIV positive status (before rapid screen) 🞏 Yes 🞏 No 🞏 Unknown Was a DCFS referral made for this family? 🞏 Yes 🞏 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 (or ED) | | / / | **:** | |
| 2. Reason for HIV screening 🞏 No PNC 🞏 No PNC record available 🞏 Repeat 3rd trimester screen | | | | |
| 3. Date/Time **maternal** sample obtained for rapid screen | / / | | | **:** |
| Test: 🞏 Oraquick 🞏 Unigold 🞏 Reveal 🞏 Combo Ag/Ab\_\_\_\_\_\_\_\_\_\_\_\_\_\_(brand) 🞏 Other\_\_\_\_\_\_\_\_\_\_  Specimen: 🞏Serum 🞏Plasma 🞏Whole blood (venous) 🞏Fingerstick Performed at: 🞏POC/L&D 🞏Lab |  | | |  |
| 4. Date/Time **Maternal** rapid screen result available | / / | | **:** | |
| 5. Date/Time **Baby** sample for rapid screen obtained (if applicable) | / / | | **:** | |
| 1. Date/Time **Baby** rapid screen result available (if applicable) | / / | | **:** | |
| 7. Reason mom not rapid screened: 🞏 offered, declined 🞏 not offered, not screened  🞏 offered, accepted but delivered before screen could be done 🞏 other | | | | |
| 8.  **Maternal** Treatment **before** Delivery: 🞏 Yes 🞏 No | | | | |
| Date/Time AZT IV started | | / / | **:** | |
| Date/Time AZT PO started | | / / | **:** | |
| Other medication started (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | / / | **:** | |
| 9. Route of Delivery | |  |  | |
| 🞏 Vaginal Delivery 🞏 Non-Emergent / Scheduled Cesarean 🞏 Emergent Cesarean 🞏 Unknown | | | | |
| 10. **Newborn** Treatment: | |  | | |
| Date/Time AZT (Zidovudine) syrup started | | / / | **:** | |
| Date/Time Nevirapine (NVP) PO started | | / / | **:** | |
| Date/Time Lamivudine (3TC) PO started | | / / | **:** | |
| **Pediatrician/Obstetrician of record is responsible for the following six items:** | | | | |
| 11. Date/Time patient informed of rapid screen results | | / / | **:** | |
| 12. Infant d/c with > 7 days AZT syrup 🞏 Yes 🞏 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 MACA when follow up information is available.** | | | | |
| 17. Supplemental Test(s): 🞏 Combo Ag/Ab 🞏 Ab differentiation 🞏 Viral Load RNA PCR 🞏Other\_\_\_\_ | | / / | **:** | |
| Result: 🞏 positive 🞏 negative 🞏 indeterminate | |
| 18. Patient informed of final result 🞏 Yes 🞏 No | | / / | **:** | |
| 19. Infant HIV-DNA PCR sent: 🞏 Yes 🞏 No Result: 🞏positive 🞏negative | | / / | **:** | |

REQUIRED FOR EVERY CASE

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical record #:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Telephone #: ( ) -

Patient’s date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Emergency Contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Additional phone #: ( ) -

**Please send this form to Mother and Child Alliance (MACA): Fax (312) 334-0973, Attn: Anne Statton.**

**For questions, call (312) 334-0974 or email** [**anne@maca-us.org**](mailto:anne@maca-us.org)