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@maca-us.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)	/ /	:
6. 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