

ISOSS HIV pregnancy notification

form date 06/23

www.ucl.ac.uk/issos

CONFIDENTIAL

HOSPITAL NAME: |

HOSPITAL CODE: |

PART 1: MATERNAL DETAILS

I. Demographic information

Date of birth: ___/___/___

Soundex:

NHS no.:

Hospital no.:

Is the woman registered with a GP? Yes No

Gender the same as when registered at birth?
 Yes F, No M, No non-binary, No - other

Ethnic origin:

White

- British
 Irish
 Any other White background

Black or Black British

- Caribbean
 African
 Any other Black background

Other Ethnic Groups

- Chinese
 Any other ethnic group, please specify.....

Mixed

- White and Black Caribbean
 White and Black African
 White and Asian
 Any other mixed background

Asian or Asian British

- Indian
 Pakistani
 Bangladeshi
 Any other Asian background

Not stated

Postcode (leave off last letter):

Country of birth: If country of birth not UK, date of arrival: ___/___/___

- Exact date/year not known, timing: during pregnancy (date not known) <1 year prior to pregnancy
 1-5 years prior to pregnancy 5-10 years prior to pregnancy >10 years prior to pregnancy

II. Social circumstances

Employment status at booking: Employed (full or part-time) Home Sick Student
 Unemployed Retired Voluntary Not known

Main support during pregnancy: Partner (cohabiting) Partner (not cohabiting) Family/friend
 Other None Not known

Employment status at booking: Employed (full or part-time) Home Sick Student
 Unemployed Retired Voluntary Not known

Any documented social/complicating issues (tick all that apply)?

- Housing concerns Intimate partner violence/domestic abuse Drug or alcohol misuse
 Mental health issues Immigration issues (incl refugee/asylum seeker) Prison/detention centre Sex work
 Social services involvement/safeguarding Learning difficulties Not engaging with healthcare services
 Financial concerns (incl accessing foodbank) None
 Other, details:

Does the woman speak English? No Yes

If yes, is English her first language? No Yes

Were translation services required? No Yes*

*If yes, was an interpreter used when screening result given? Yes, independent person (phone or present in the room) Yes, other: No, interpreter not available Not known

Which language did the woman require translation services for?

III. Obstetric history

Gravida..... Parity.....+..... Date(s) of previous livebirths if known: _____

Obstetric history not known

PART 2: PREGNANCY AND ANTENATAL CARE DETAILS

Woman known to have booked at another hospital in this pregnancy? No Yes, details

Woman known to be transferring her pregnancy care to another hospital? No Yes, details

Date booked for antenatal care at your hospital: ___/___/___ Unbooked (arrived in labour)

Was there a delay to the woman being booked No Yes, reason

Maternal weight at booking kg maternal height at booking cm

Is this an IVF pregnancy? Yes No Not known

Estimated date of delivery (by ultrasound): ___/___/___

Pregnancy status:
 Continuing to term
 Miscarriage* – date: ___/___/___ at weeks gestation
 Termination* – date: ___/___/___ at weeks gestation
 *If miscarriage or termination, any congenital conditions? No Yes:

Infant feeding intention at booking: Breastfeeding Artificial (formula) feeding Not yet decided

PART 3: ANTENATAL HIV SCREENING

Was IDPS screening offered and accepted for all infections? Yes No, reason.....

Was HIV diagnosis a result of the IDPS screening? Yes No, details.....

Date screening sample taken: ___/___/___

Date first seen by a member of the screening team: ___/___/___

Was the result given to the woman within 5 working days? Yes No, [See Screening Standard IDPS-S05 \(referral: timely assessment of screen positive and known positive women\)](#)
 reason:

Was this appointment: face to face virtual via phone virtual other , details.....

Previously screened negative in **this** pregnancy? date of screen negative result ___/___/___

Date first seen by HIV specialist services in this pregnancy: ___/___/___

If **newly diagnosed** and not seen within 2 weeks, reason:.....

PART 4: INFECTION HISTORY

Likely exposure:
 Sexual, specify partner's likely risk factor if known:
 Vertical transmission, specify place and age at diagnosis:
 Injecting drug use
 Other, specify:

First Diagnosed when: During this pregnancy or Before this pregnancy

Date of diagnosis: ___/___/___

Diagnosed where: Antenatal Sexual health clinic Other, specify:

Has this woman ever had an AIDS defining illness? No Yes, date of onset.....
 Details..... Not known

Is the GP aware of the woman's HIV diagnosis? Yes No Not known

PART 5: DRUG TREATMENT DURING THIS PREGNANCY

Was this woman on antiretrovirals when she became pregnant? No Yes

Did she receive antiretrovirals during pregnancy? No Yes Not yet Declined

Antiretroviral drugs	Before preg?	Date started (or gest. week)	Date stopped (or gest. week)
Drug 1	Yes / No	___/___/___	___/___/___
Drug 2	Yes / No	___/___/___	___/___/___
Drug 3	Yes / No	___/___/___	___/___/___
Drug 4	Yes / No	___/___/___	___/___/___

PART 6: MATERNAL CLINICAL STATUS

Symptomatic in this pregnancy? No Yes, specify:

Concurrent maternal infection(s)? None HBV HCV Syphilis Other, specify:

PART 7: MATERNAL TEST RESULTS

Please provide the first test results available in this pregnancy.

Viral load: _____ copies/ml Date: ___/___/___ **CD4:** _____ (____%) Date: ___/___/___

PART 8: ADDITIONAL INFORMATION

Please enter any additional information in the space below

