ISOSS HIV maternity outcome

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CONFIDENTIAL

Your ref: [Pre-populated] **EDD:** [Pre-populated] **Hospital of delivery:**

PART 1: CHILD INFORMATION

☐ **Livebirth** or ☐ **Stillbirth** (please include details in notes)
If twins*, tick here: ☐
(*) Please add details of twin 2 in part 6; If >2 please add child information to notes (Part 5)

Date of birth: ____/____/____ **Gest.:** …….. wks ☐ **Male** or ☐ **Female** ☐ **Indeterminate**

Birthweight: …….. kg **Birth head circumference:** …….. cm

Hospital no. ……..
NHS no. ……..
Paediatrician: ……..

Congenital anomalies? ☐ No ☐ Yes: ……
Neonatal infections? ☐ No ☐ Yes: ……
Other neonatal complications? ☐ No ☐ Yes: ……
Planned mode of infant feeding?
☐ Planning to formula feed only ☐ Planning to breastfeed*
*please give details in part 8 of form

PART 2: PREGNANCY AND DELIVERY DETAILS

Postcode at delivery (leave off last letter): ☐☐☐☐ ☐☐■

Social complicating issues reported at notification: [textbox with any notes from other]
Any additional issues identified by delivery:
☐ Housing concerns ☐ Intimate partner violence/domestic abuse ☐ Drug or alcohol misuse
☐ Mental health issues ☐ Immigration issues (incl refugee/asylum seeker) ☐ Prison ☐ Sex work ☐ Social services involvement/safeguarding ☐ Learning difficulties ☐ Not engaging with healthcare services
☐ Financial concerns (incl accessing foodbank) ☐ None
☐ Other, details: ……

Pregnancy complications:
☐ None
☐ Pre-eclampsia
☐ Gestational diabetes
☐ Other: ……
……

Invasive procedures in pregnancy:
☐ None ☐ Amniocentesis
☐ CVS ☐ Cordocentesis

If yes, date of procedure: ____/____/____
Viral load at procedure:…….. copies/ml

Mode of delivery:
☐ 1. Planned vaginal delivery
☐ 2. Elective CS
☐ 3. Unplanned vaginal delivery
☐ 4. Emergency CS
Reason for delivery by 2, 3 or 4: ……
***Planned* mode of delivery:** ☐ Vaginal ☐ Elective CS ☐ Not known

Invasive procedures at delivery (tick all that apply):
☐ None
☐ Ventouse
☐ Forceps, type: ……
☐ Scalp monitor
☐ FBS

Symptomatic at delivery?
☐ No ☐ Yes: ……
If died, date of death: ____/____/____
Details: ……

Rupture of membranes? ☐ No / Only at delivery ☐ Yes, duration: …… hours …… minutes

If available: Maternal weight in 3rd trimester …….. kg **date:**_____/____ /_____

PART 3: DRUG TREATMENT DURING PREGNANCY

Antiretroviral drugs:	**Date started (or gest. week)**	**Date stopped (or gest. week)**
Drug 1 ……	____/____/____ _____	____/____/____ _____
Drug 2 ……	____/____/____ _____	____/____/____ _____
Drug 3 ……	____/____/____ _____	____/____/____ _____

Any other significant drugs (e.g. anticoagulants, anti-depressants, antibiotics, illicit drugs):
Drug 1 …… Date: ____/____/____ Drug 2 …….. Date: ____/____/____
Was this woman given additional antiretrovirals during labour/delivery? *(See 8.4 of the BHIVA guidelines)*
☐ None ☐ IV AZT ☐ Single dose nevirapine ☐ Other oral antiretrovirals: ……

Was this infant treated with antiretrovirals as part of post-exposure prophylaxis? *(See section 9.1 of the BHIVA guidelines)* ☐ None, reason…… ☐ Oral AZT ☐ IV AZT ☐ Triple, specify:
……
Timing (hours) given after birth ☐ <4hours, ☐ 4 -72 hours, reason…… ☐ >72hours, reason……

PART 4: MATERNAL TEST RESULTS NEAR DELIVERY

If delivered ≥36 weeks, was a viral load done at 36 weeks gestation? ☐ Yes ☐ No, reason……
(See section 5.2.5 of the BHIVA guidelines)

Please provide the test results available closest to delivery (i.e. viral load on day of delivery or within 30 days prior to or 7 days post delivery)
Viral load: _____ copies/ml Date: ____/____/____ **CD4:** _____ (_____%) Date: ____/____/____

**Please note maternal viral load at delivery is used to determine whether additional treatment at delivery and duration of infant post-exposure prophylaxis*
No viral load within 30 days prior to or 7 days post delivery, reason……
(See section 5.2.5 of the BHIVA guidelines)

Any concerns about the woman's viral load in pregnancy (i.e. detectable VL)? ☐ Yes ☐ No ☐ Not known
If yes, please provide any relevant details including viral load blips (and dates) and any changes in pregnancy management……

Please enter any additional relevant information in the space below.

PART 5: ADDITIONAL INFORMATION

Please complete parts 6 and 7 in the case of a twin pregnancy.

PART 6: CHILD INFORMATION FOR SECOND TWIN

☐ **Livebirth** or ☐ **Stillbirth**	**Date of birth:** ____/____/____	**Gest** …….. wks	☐ **Male** or ☐ **Female** ☐ **Indeterminate**
	Birthweight …….. kg	**Birth head circumference** …….. cm	
Hospital no. …….. **NHS no.** …….. **Paediatrician:** ……..	**Congenital anomalies?** ☐ No ☐ Yes: …… **Neonatal infections?** ☐ No ☐ Yes: …… **Other neonatal complications?** ☐ No ☐ Yes: …… **Planned mode of infant feeding?** ☐ Planning to formula feed only ☐ Planning to breastfeed* *please give details in part 8 of form		

PART 7: TWIN CHORIONICITY AND AMNIONICITY

Chorionicity: ☐ Monochorionic ☐ Dichorionic ☐ Chorionicity not known

Amnionicity: ☐ Monoamniotic ☐ Diamniotic ☐ Amnionicity not known

Please complete part 8 *if this mother is planning to breastfeed.*

PART 8: BREASTFEEDING CIRCUMSTANCES

Is breastfeeding being managed in line with current BHIVA Guidelines*? ☐ No ☐ Yes ☐ Not known

*Please be aware that breastfeeding is not recommended in the current BHIVA Guidelines. See BHIVA Guidelines 9.4 Infant Feeding

What are the reasons for wanting to breastfeed? *Please tick boxes that most closely fit this case.*
☐ Bonding
☐ Health benefits for baby/mother
☐ Financial concerns
☐ Concerns about disclosure of HIV status
☐ Breastfed previously (before diagnosis)
☐ Breastfed previously (after diagnosis)
☐ Family/friends expectations/pressure
☐ Other, details: ……
……

What is the intended duration of breastfeeding? …….. **weeks / months** or ☐ Not known

GP aware of mother's HIV status? ☐ No ☐ Yes ☐ Not known
Partner aware of mother's HIV status? ☐ No ☐ Yes ☐ Not known

Please provide any other information related to management of breastfeeding here: