NSHPC outcome of notified pregnancy

MREC approval ref: MREC/04/2/009 *form date 01/20* www.ucl.ac.uk/nshpc

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Please complete all required sections of this form.

Your ref: EDD: Hospital of delivery:

PART 1: CHILD INFORMATION

☐ **Livebirth** or ☐ **Stillbirth**
If twins*, tick here: ☐
*Please give details of second twin overleaf and if multiple please give details in Part 5

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

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

Hospital no. ……..
NHS/CHI no. ……..
Paediatrician: ……..

Congenital abnormalities? ☐ No ☐ Yes: ……
Perinatal infections? ☐ No ☐ Yes: ……
Infant problems? ☐ 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): ☐☐☐☐ ☐☐■

Pregnancy complications:
☐ None
☐ Pre-eclampsia*
☐ Gestational diabetes
☐ Other: ……
……
*please give details overleaf

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

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

Mode of delivery:
☐ 1. Elective CS to prevent mother-to-child transmission
☐ 2. Planned vaginal delivery
☐ 3. Elective CS for any other reason
☐ 4. Unplanned vaginal delivery
☐ 5. Emergency CS
Reason for delivery by 3, 4, or 5: ……
……
***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: ____/____/____

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

PART 3: DRUG TREATMENT DURING PREGNANCY

Antepartum treatment (i.e. treatment in pregnancy)? ☐ No ☐ Yes
If yes, reason for treatment: ☐ Prevention of mother-to-child transmission ***only***
☐ Maternal health ***and*** prevention of mother-to-child transmission

Antiretroviral drugs:	**Date started (or gest. week)**	**Date stopped (or gest. week)**
Drug 1 ……..	____/____/____ _____	____/____/____ _____
Drug 2 ……..	____/____/____ _____	____/____/____ _____
Drug 3 ……..	____/____/____ _____	____/____/____ _____
Drug 4 ……..	____/____/____ _____	____/____/____ _____
Drug 5 ……..	____/____/____ _____	____/____/____ _____

Any other significant drugs (e.g. anticoagulants, anti-depressants, antibiotics, illicit drugs):
Drug 1 …… Date: ____/____/____ Drug 2 …….. Date: ____/____/____

Additional treatment intra-partum:
☐ None ☐ IV AZT ☐ Single dose nevirapine ☐ Other oral antiretrovirals: ……

Post-partum for infant:
☐ None ☐ Oral AZT ☐ IV AZT ☐ Triple, specify: ……

PART 4: MATERNAL TEST RESULTS NEAR DELIVERY

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

Form completed by: Name: _____ Date: ____/____/____
Position: _____ Telephone: _____ Email: _____

Please return to: CONFIDENTIAL, FAO H Peters, Surveillance Studies Group PPP Programme, UCL Institute of Child Health, 30 Guilford St, London WC1N 1EH. Telephone 020 7905 2739 or email nshpc@ucl.ac.uk for queries (helen.peters2@nhs.net for those with identifiers).

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**
	Birthweight …….. kg	**Birth head circumference** …….. cm	
Hospital no. …….. **NHS/CHI no.** …….. **Paediatrician:** ……..	**Congenital abnormalities?** ☐ No ☐ Yes: …… **Perinatal infections?** ☐ No ☐ Yes: …… **Infant problems?** ☐ 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 8.4 Infant Feeding: https://www.bhiva.org/file/FCUcXrfVgWsYI/BHIVA-Pregnancy-guidelines-update-2014.pdf.
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 (circle) 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:

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