**CONFIDENTIAL**

HOSPITAL NAME: HOSPITAL CODE:

HOSP

**ISOSS HIV pregnancy notification**

***form date 07/21*** [**www.ucl.ac.uk/isoss**](http://www.ucl.ac.uk/isoss)

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| --- | --- | --- | --- | --- |
| **PART 1: MATERNAL DETAILS** | | | | |
| I. Demographic information | | | | |
| **Date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Soundex:** ……………… | | | |
| **NHS no.:** …………………………………… | **Hospital no.: ………………………………** | | | |
| |  |  |  | | --- | --- | --- | | **Ethnic origin:** | | | | ***White***  British  Irish  Any other White background  ***Mixed***  White and Black Caribbean  White and Black African  White and Asian  Any other mixed background | ***Black or Black British***  Caribbean  African  Any other Black background  ***Asian or Asian British***  Indian  Pakistani  Bangladeshi  Any other Asian background | ***Other Ethnic Groups***  Chinese  Any other ethnic group  Not stated | | | | | |
| **Postcode (leave off last letter):** □□□□ □□■ | | | | |
| **Country of birth:** ………………………………………… If country of birth not UK, date of arrival: \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| 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  Drug or alcohol misuse  Mental health issues  Immigration problems  Prison  Sex work  Social services involvement  Learning difficulties  Not engaging with healthcare services  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 | | | | |
| III. Obstetric history | | | | |
| ***Previous pregnancies***  …….. **livebirth(s)**, date(s) if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | …….. **stillbirth(s)** | …….. **miscarriage(s)/TOP(s)** |
| **PART 2: INFECTION HISTORY** | | | | |
| **Maternal infection probably acquired:**  In the UK  Abroad, specify: …………………….....  Not known | | | | |
| **Likely exposure:**  Heterosexual, specify partner’s likely risk factor if known: ……………………………………………………………….  Vertical transmission, specify place and age at diagnosis: ………………………………………………………….…  Injecting drug use  Other, specify: ................................................................................................................................................................. | | | | |
| **Date of 1st positive test:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| **Diagnosed *when*:**  During this pregnancy or  Before this pregnancy | | | | |
| **Diagnosed *where*:**  Antenatal  Sexual health clinic  Other, specify: …………………………………………… ………………………………………………………………………………………………………………………………………….. | | | | |
| **Any evidence of seroconversion in this pregnancy?**  No  Yes (specify details in notes)  Not known | | | | |
| **PART 3: PREGNANCY AND ANTENATAL CARE DETAILS** | | | | |
| **Date referral received by maternity:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | **Date booked for antenatal care:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | |
| **Maternal weight at booking** ………... kg **maternal height at booking** ………... cm | | | | |
| **Is this an IVF pregnancy?**  Yes  No Not known | | | | |
| **Date of first positive test result in pregnancy/date known HIV-positive:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| **Date first seen by screening coordinator/screening team:** \_\_\_\_/\_\_\_\_/\_\_\_\_ ([See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women](https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards))  If more than 10 working days between positive lab result and screening appointment, reason: …………………..  …………………………………………………………………………………………………………………………………………… | | | | |
| **Estimated date of delivery (by ultrasound):** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| **Pregnancy status:**  Continuing to term – planned mode of delivery:  Vaginal  CS  Not yet decided  Miscarriage\* – date: \_\_\_\_/\_\_\_\_/\_\_\_\_ at .……. weeks gestation  Termination\* – date: \_\_\_\_/\_\_\_\_/\_\_\_\_ at .……. weeks gestation  \*If miscarriage or termination, any congenital anomaly?  No  Yes: …………………………………………….. | | | | |
| **Infant feeding intention at booking**:  Breastfeeding  Artificial (formula) feeding  Not yet decided | | | | |
| **PART 4: 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  Drug 5 …………………………………. Yes / No \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ | | | | |
| **PART 5: MATERNAL CLINICAL STATUS** | | | | |
| **Symptomatic in this pregnancy?**  No  Yes, specify: …………………………………………………………………...  **Concurrent maternal infection(s)?**  None  HBV  HCV  Syphilis  Other\*, specify: ……………………..  \*please inform us if Covid-19 has been suspected/diagnosed in the pregnancy | | | | |
| **PART 6: MATERNAL TEST RESULTS** | | | | |
| *Please provide the first test results available in this pregnancy.*  **Viral load:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ copies/ml Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **CD4:** \_\_\_\_\_\_\_\_\_ (\_\_\_\_\_%) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | |
| **PART 7: ADDITIONAL INFORMATION** | | | | |
| COVID-19 vaccine received  Yes  No  Not known  If 'Yes', please specify below which vaccine, number of doses and dates if known: …………………………… …………………………………………………………………………………………………………………………………….. | | | | |
| Please enter any additional information in the space below: | | | | |