**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.: ………………………………** |
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| --- |
| **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 knownIf 'Yes', please specify below which vaccine, number of doses and dates if known: …………………………… …………………………………………………………………………………………………………………………………….. |
| Please enter any additional information in the space below:  |