**CONFIDENTIAL**

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

**……**……………………………..

**ISOSS HIV maternity outcome**

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

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| **PART 1: CHILD INFORMATION** |
| [ ]  **Livebirth** or [ ]  **Stillbirth** (please include details in additional information, part 5)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: ……………………………………….**Perinatal infections?** (please inform us if Covid-19 has been suspected or diagnosed in the pregnancy)[ ]  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: ………………………………………………………….………………………………………………………………........... | **Invasive procedures in pregnancy:**[ ]  None [ ]  Amniocentesis[ ]  CVS [ ]  CordocentesisIf yes, date of procedure: \_\_\_\_/\_\_\_\_/\_\_\_\_Viral load at time of procedure:……….. copies/ml Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **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:\_\_\_\_\_/\_\_\_\_ /\_\_\_\_\_** **Maternal weight at booking** [pre-populated]…… kg **maternal height at booking** [pre-populated …... cm  |
| **PART 3: DRUG TREATMENT DURING PREGNANCY** |
| **Antiretroviral treatment (ART) in pregnancy?** [ ]  No [ ]  Yes |
| **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** |
| Please provide the test results available closest to delivery (i.e. viral load within 30 days prior to or 7 days post delivery)**Viral load:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ copies/ml Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **CD4:** \_\_\_\_\_\_\_\_\_ (\_\_\_\_\_%) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |

**Please enter any additional relevant information in the space below.**

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| **PART 5: ADDITIONAL INFORMATION** |
| COVID-19 vaccine received [ ]  Yes [ ]  No [ ]  Not knownIf 'Yes', please specify below which vaccine, number of doses and dates if known: …………………………….… ………………………………………………………………………………………………………………………………………… |
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**Please complete parts 6 and 7 in the case of a twin pregnancy.**

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| **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 anomalies?** [ ]  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.***

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| **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/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rd-interim-update.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** [ ] 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: |