**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  Cordocentesis  If 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 known  If '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: |