PRTII Preliminary Positive Data Collection Form

1. Immediately call the 24-hour IL Perinatal HIV Hotline at (800) 439-4079 **to report all** preliminary positive rapid test results.
2. Complete reporting institution information box **for all calls.**
3. Complete the delivery and treatment information box for **all** positive rapid test results.
4. Complete the patient information box ***only*** if a release of information is signed by the patient. If release is signed, PACPI will assist with case management and follow-up at your request.

Staff filling out form: _____ Staff phone number_____
Delivery Hospital/City:_____ Date of Delivery: _____/_____/_____ Time of Delivery _____:_____
Maternal age: _____ Maternal race _____ G _____ P _____
Prenatal Care: ☐ None ☐ Sporadic ☐ Routine
Type: ☐ Hospital Clinic ☐ Private Office ☐ Health Dept Clinic
In the opinion of the staff, did the patient know her HIV positive status (even before the rapid test was performed) ☐ Yes ☐ No ☐ Unknown Was a DCFS referral made for this family? ☐ Yes ☐ No

Complete the following (including dates and times) for *all* patients with a preliminary positive rapid test.

	Date (MM/DD/YYYY)	Time (24 hour clock)
1. Presentation at L & D	/ /	:
2. Reason for undocumented HIV status ☐ No PNC ☐ No PNC record available ☐ Not tested antenatally (not offered / declined)		
3. Date/Time **maternal** sample obtained for rapid test Test Brand used: ☐ Oraquick ☐ Unigold ☐ Reveal ☐ Multispot ☐ Other Rapid Test performed at: ☐ POC/L&D ☐ Lab	/ /	:
4. Date/Time **Maternal** rapid test result available	/ /	:
5. Date/Time **Baby** sample for rapid test obtained (if applicable)	/ /	:
6. Date/Time **Baby** rapid test result available (if applicable)	/ /	:
7. Reason mom not rapid tested: ☐ offered, declined ☐ not offered, not tested ☐ offered, accepted but delivered before test could be done ☐ other		
8. **Maternal** Treatment **before** Delivery: ☐ Yes ☐ No		
Date/Time AZT IV started	/ /	:
Date/Time AZT PO started	/ /	:
Other medication started (specify:_____)	/ /	:
9. Route of Delivery ☐ Vaginal Delivery ☐ Non-Emergent / Scheduled Cesarean ☐ Emergent Cesarean ☐ Unknown		
10. **Newborn** Treatment:		
Date/Time AZT syrup started (Was it within 12 hours of birth?☐ Yes☐ No)	/ /	:
Date/Time Nevirapine PO started	/ /	:
Other (specify:_____)	/ /	:
Pediatrician/Obstetrician of record is responsible for the following six items:		
11. Date/Time patient informed of rapid test results	/ /	:
12. Infant d/c with ≥ 7 days AZT syrup ☐ Yes ☐ No	/ /	:
13. Newborn HIV care referral made to (place):_____	/ /	:
14. Mother HIV care referral made to (place):_____	/ /	:
15. IL Perinatal HIV Hotline called: (800) 439-4079 (required by IDPH rules)	/ /	:
16. Local Dept Public Health called (if applicable)	/ /	:
Follow up: Please complete and re-fax form to PACPI when follow up information is available.		
17. Confirmatory Western Blot test sent: Result: ☐ positive ☐ negative ☐ indeterminate	/ /	:
18. Patient informed of Western Blot result ☐ Yes ☐ No	/ /	:
19. Infant HIV-DNA PCR sent: ☐ Yes ☐ No Result: ☐positive ☐negative	/ /	:

Patient's name: _____ Medical record #: _____
Address: _____ Home Telephone #: (____)_____-_____
Patient's date of birth ____/____/_____ Emergency Contact info: _____

revised 09/19/2006