ISOSS HIV maternity outcome

form date 04/24 www.ucl.ac.uk/isoss

CONFIDENTIAL

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

PART 1: CHILD INFORMATION

☐ **Livebirth** or ☐ **Stillbirth** (please complete part 9)
If twins*, tick here: ☐
(*) Please add details of twin 2 in part 7; If >2 please add child information to notes (Part 6)

Date of birth: ____/____/____ **Gest.:** ….. wks +…..days ☐ **Male** or ☐ **Female** ☐ **Indeterminate**

Birthweight: …….. kg If baby died, date of death: ____/____/____ (please complete part 9)

Hospital no. ……..
NHS no. ……..
Paediatrician: ……..

Congenital conditions? ☐ No ☐ Yes: …… ☐ NK
Neonatal infections? ☐ No ☐ Yes: …… ☐ NK
Other neonatal complications? ☐ No ☐ Yes: …… ☐ NK
Admitted to neonatal unit? ☐ No ☐ Yes: …… ☐ NK

PART 2: PREGNANCY AND DELIVERY DETAILS

Postcode at delivery (leave off last letter): ☐☐☐☐ ☐☐■

Social complicating issues reported at notification: [textbox with any notes from other]
Any additional issues identified by delivery:
☐ Housing concerns ☐ Intimate partner violence/domestic abuse ☐ Drug or alcohol misuse
☐ Mental health issues ☐ Immigration issues (incl refugee/asylum seeker) ☐ Prison/detention centre
☐ Sex work ☐ Social services involvement/safeguarding ☐ Learning difficulties
☐ Not engaging with healthcare services ☐ Financial concerns (incl accessing foodbank) ☐ None
☐ Other, details: ……

Pregnancy complications:
☐ None
☐ Pre-eclampsia
☐ Gestational diabetes
☐ Other: ……
……

Invasive procedures in pregnancy:
☐ None ☐ Amniocentesis
☐ CVS ☐ Cordocentesis

If yes, date of procedure: ____/____/____
Viral load at procedure:…….. copies/ml

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 woman died, date of death: ____/____/____
Details: ……

Rupture of membranes? ☐ No / Only at delivery ☐ Yes, duration: …… hours …… minutes

Maternal weight in 3rd trimester (if available): …….. kg **Date:**_____/____ /_____

PART 3: DRUG TREATMENT DURING PREGNANCY AND INFANT POSTNATAL PROPHYLAXIS

Antiretroviral drugs:	**Date started (or gest. week)**	**Date stopped (or gest. week)**
Drug 1 ……	____/____/____ _____	____/____/____ _____
Drug 2 ……	____/____/____ _____	____/____/____ _____
Drug 3 ……	____/____/____ _____	____/____/____ _____

Any other significant drugs (e.g. anticoagulants, anti-depressants, antibiotics, illicit drugs):
Drug 1 …… Date: ____/____/____ Drug 2 …… Date: ____/____/____
Was the woman given additional antiretrovirals during labour/delivery? *(See 8.4 of the BHIVA guidelines)*
☐ None ☐ IV AZT ☐ Single dose nevirapine ☐ Other oral antiretrovirals: ……

Was the infant treated with antiretrovirals as part of postnatal prophylaxis (PNP)? *(See section 9.1 of the BHIVA guidelines)* ☐ None, reason…… ☐ Oral AZT ☐ IV AZT ☐ Triple, specify:
……
Timing of infant PNP start: ☐ Within 4 hours of birth ☐ Within 4 to 72 hours of birth, reason: ……
☐ Beyond 72 hours of birth, reason: ……

PART 4: MATERNAL TEST RESULTS

If delivered ≥36 weeks, was a viral load done at 36 weeks gestation? ☐ Yes ☐ No, reason……
(See section 5.2.5 of the BHIVA guidelines)

Please provide the test results available closest to delivery (i.e. viral load on day of delivery or within 30 days prior to or 7 days post delivery)
Viral load: _____ copies/ml Date: ____/____/____ **CD4:** _____ (_____%) Date: ____/____/____

**Please note maternal viral load at delivery is used to determine whether additional treatment at delivery and duration of infant post-exposure prophylaxis*
No viral load within 30 days prior to or 7 days post delivery, reason……
(See section 5.2.5 of the BHIVA guidelines)

Any concerns about the woman's viral load in pregnancy (i.e. detectable VL)? ☐ Yes ☐ No ☐ Not known
If yes, please provide any relevant details including viral load blips (and dates) and any changes in pregnancy management……

PART 5: INFANT FEEDING

Is formula milk made freely available to women living with HIV in the local area?
☐ No ☐ Yes ☐ Not known

What was the <u>planned</u> mode of infant feeding at delivery (regardless of actual feeding outcome)?
☐ Planning to formula feed only ☐ Planning to breastfeed

Was cabergoline given?
☐ No ☐ Yes ☐ Not known

Date mother and baby discharged from postnatal maternity services, including community midwifery services: ___/___/___

Was the infant breastfed or given expressed breastmilk <u>at any point prior to discharge</u> from maternity services?
☐ No ☐ Yes ☐ Not known

Reason not breastfed despite intention to breastfeed: ……
……

Was the woman supported to breastfeed (i.e., were clinical team aware and involved in management)?
☐ No, details: ……
☐ Yes, details of support and management arranged: ……
☐ Not known *(see section 9.4 of the BHIVA guidelines)*

Reasons for wanting to breastfeed (select all that apply):
☐ Bonding ☐ Health benefits for baby/mother ☐ Financial
☐ Breastfed previously (before diagnosis) ☐ Breastfed previously (after diagnosis)
☐ Family/friends expectations/pressure concerns ☐ Concerns about disclosure of HIV status ☐ Not known
☐ Other, details: ……

Date breastfeeding commenced: ☐ At birth ☐ Other date: ___/___/___

Intended duration for the breastfeeding: …… day(s) OR ……week(s) OR ……month(s)

Was there any mixed feeding (i.e., breast milk with formula milk or other liquid(s)) prior to discharge?
☐ No, exclusively breastfed
☐ Yes, temporary supplementation with formula milk whilst establishing breastfeeding in the neonatal period
☐ Yes, other: ……
☐ Not known

Was breastfeeding ongoing at the point of discharge from hospital?
☐ No ☐ Yes ☐ Not known

Date all breastfeeding stopped: ___/___/___

Main reason for stopping all breastfeeding (select one):
☐ Part of plan to stop
☐ Difficulties establishing breastfeeding (e.g., unable to latch) (avoidance of mixed feeding)
☐ Infant required supplementation (avoidance of mixed feeding)
☐ Clinical concerns in mother (e.g., maternal viraemia, mastitis, gastroenteritis):
……..
☐ Clinical concerns in infant (e.g., gastroenteritis):
……
☐ Other: ……

Additional information regarding infant feeding: ……
……

Please enter any additional relevant information in the space below.

PART 6: ADDITIONAL INFORMATION

Please complete parts 7 and 8 in the case of a twin pregnancy.

PART 7: CHILD INFORMATION FOR SECOND TWIN			
☐ **Livebirth** or ☐ **Stillbirth** (please complete part 9)	**Date of birth:** ____/____/____	**Gest** ……. wks +……..days	☐ **Male** or ☐ **Female** ☐ **Indeterminate**
	Birthweight ……... kg	If baby died, date of death: ____/____/____ (please complete part 9)	
Hospital no. ……... **NHS no.** …….. **Paediatrician:** ……...	**Congenital conditions?** ☐ No ☐ Yes: …….. ☐ NK **Neonatal infections?** ☐ No ☐ Yes: …….. ☐ NK **Other neonatal complications?** ☐ No ☐ Yes: …… ☐ NK		
PART 8: TWIN CHORIONICITY AND AMNIONICITY			
Chorionicity: ☐ Monochorionic ☐ Dichorionic ☐ Chorionicity not known			
Amnionicity: ☐ Monoamniotic ☐ Diamniotic ☐ Amnionicity not known			

Please complete part 9 in the case of a stillbirth or neonatal death

PART 9: ADDITIONAL DETAILS OF STILLBIRTHS AND NEONATAL DEATHS

Was HIV through to have caused or contributed to the stillbirth or neonatal death? ☐ Yes ☐ No
What was the cause of death reported as? ……
Was a postmortem accepted? ☐ Yes ☐ No
Were fetal swabs sent? ☐ Yes ☐ No
Were placental swabs sent? ☐ Yes ☐ No
Were placental swabs sent for histology? ☐ Yes ☐ No
Were fetal blood samples sent for infection testing? ☐ Yes ☐ No
Were maternal blood samples sent for infection testing? ☐ Yes ☐ No