Maternal-Pediatric HIV Prevention and Care Program Test History and Assessment

...d instructions on reverse.

Mother's Addressograph

Mother's Information (Enter only information not on addressograph)

Mother's Name

Street Address

City, State Zip Code

Mother's Telephone Number

Mother's Medical Record Number

Newborn's Information

Baby's Name of Record

Name to be Used by Baby (If Different)

Baby's Date of Birth

Baby's Medical Record Number

Newborn Screening Program Number

III. Prenatal Care Provider

Name (Indicate "None" If No Prenatal Care)

Street Address

City, State, Zip Code

IV. Physician/Provider Responsible for Baby After Discharge

Name

Street Address

City, State, Zip Code

...enatal HIV Counseling History Counseled during the current pregnancy: ☐ Yes ☐ No

1) **HIV Test History at Delivery** (Prenatal HIV Test History) - Check one from A → D; indicate source of HIV test history information.

A. **Tested HIV negative during *this* pregnancy**; check source of information (be sure test date falls within this prenatal period):
- ☐ Hard copy of laboratory report in the record, or
- ☐ Written note, signed by a clinician, indicating the date of HIV testing and the test result, or
- ☐ Computer/electronic record indicating the date of HIV testing and the test result.

☐ B. **Tested HIV positive during or prior to this pregnancy.** Check source of information:
- ☐ Hard copy of laboratory report in the record, or
- ☐ Written note, signed by a clinician, indicating the date of HIV testing and the test result, or
- ☐ Computer/electronic record indicating the date of HIV testing and the test result.

☐ C. **Not tested during this pregnancy**

☐ D. **Test history unknown/not documented**

(2) **In-Hospital Testing - Expedited HIV Testing Status** - Check one from E→G; document in the appropriate medical record.

☐ E. If the mother received expedited HIV testing (with consent), check box "E". (Note: If there is documentation of a negative prenatal HIV test and the mother has also signed consent for an expedited HIV test at the time of delivery, boxes "A" and "E" should be checked.)

☐ F. **Newborn tested**

☐ G. **Testing not needed** (Mother tested negative during this pregnancy or is HIV positive).

(3) If a *preliminary positive expedited* HIV test result was received has the DOH-4159 form (*Report on Preliminary Positive HIV Test Results*) been submitted to the NYS DOH as required? ☐ Yes ☐ No ☐ N/A

VII. HIV Care Status (Complete if the mother is HIV infected).

(1) Has mother received health care services for HIV infection? ☐ Yes ☐ No ☐ Unknown

(2) Have arrangements for post-discharge treatment been made for the newborn and offered to the mother?

Newborn ☐ Yes ☐ No Mother ☐ Yes ☐ No

VIII. What special support, if any, might this mother need if she were to receive a positive HIV test result? (Vulnerable populations may include adolescents and/or women with a history of domestic violence, substance abuse and mental health problems.)

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...completing form ______________________ (Print Name) ______________________ (Signature) Date ________

This form contains HIV-related information that is protected by the confidentiality provisions of Public Health Law Article 27-F.

WHITE - HIV Designee YELLOW - Mother's Medical Record PINK - Baby's Medical Record

(2/05)