INSTRUCTIONS FOR COMPLETING THE DISTRICT OF COLUMBIA HIV AND PREGNANCY CASE REPORT FORM AUGUST 2013

This case report form should be completed for all women with a new pregnancy and evidence of HIV infection (including AIDS), and return to the Strategic Information Bureau within 48 hours of confirmation of the diagnosis of pregnancy. Instructions for filling out the form are found below. The form may be photocopied or downloaded from the Department of Health (DOH) webpage on **www.doh.dc.gov/page/doh-applications-and-forms**. Copies of the form may be obtained from the DOH HIV/AIDS, Hepatitis, STD, and TB Administration by calling (202) 671-4900.

This case report form is designed to collect information to promote the understanding of HIV infection and AIDS morbidity and mortality. This information is also going to be used for public health purposes to help ensure the health of the pregnant woman and prevent the transmission of a communicable disease. Some case report information may be shared at the national level. *All personal identifiers will be removed before any information is transmitted.* DOH follows strict protocols to protect the security and confidentiality of patient level information.

Patients for whom this form is indicated include following patients:

- Any HIV-infected woman who is diagnosed with a pregnancy AND
- Is a District resident

Completed case report forms should be faxed to (202) 671-5094. Alternatively completed forms can be mailed in a double-sealed envelope marked "confidential" to the Department of Health – Box 19, 899 North Capitol Street, NE, Washington, DC 20002 or may be hand delivered addressed as above.

Date
Enter the date that the form is being completed.

Patient Information
Enter the patient's last name, first name and middle initial. If available, write in any other names, a.k.a., aliases, maiden name, or prior legal name.

Address
Enter the patient's current home address including city, state and zip code.

Telephone Number
Enter the patient's best contact telephone number including the area code.

Birth Date
Enter the patient's month, day and year of birth in the mm dd yyyy format.

Date of Pregnancy Diagnosis
Enter the date of the diagnosis of the pregnancy

Race
This field should be completed. More than once choice can be made if applicable. If no race information is available, select unknown.

Linkage to Care
Answer the first three questions 'Yes' or 'No'. If information on the current medication regimen is available include it in the space provided. Enter the Estimated date of delivery (EDD). Enter the date of HIV diagnosis if available.

Provider information
Enter the first and last name, and the credentials (MD, DO, NP, etc.) of the provider making the report.

Hospital/Facility Name
Provide the name of the facility. If it is a private office indicate that here.

Facility Address
Provide the address of the facility including the city, state, and zip code.

Telephone Number
Enter the provider's telephone number and fax number including the area code.

Person completing form
If the person completing the form is someone besides the provider, enter that name here.

Remaining check boxes
If you have concerns about any of the listed choices, check any boxes that apply.