FIMR/HIV PREVENTION METHODOLOGY
NATIONAL RESOURCE CENTER

Prior-to-Pregnancy Syphilis Care

Case Number: ______________________

Abstraction Completion Date: ___/___/___

1) This form collects information relating to the health care the mother received *during the year prior* to this pregnancy. Please indicate the sources used to complete this form (check all that apply):
   ☐ HIV Care Record
   ☐ Prenatal Care Record
   ☐ Hospitalization Record
   ☐ Case Management Record
   ☐ Other (*specify*): ______________________
   ☐ Other (*specify*): ______________________

Please confirm that information entered in this form occurred during the year prior to this pregnancy.

Introductory Information

2) For each type of care, indicate where the services were received and the provider type prior to this pregnancy *(check all that apply)*

	Gynecological/Family Planning Care	General primary care	HIV Care	Pre-existing DX Follow-Up	Other care (specify)
Care not received	☐	☐	☐	☐	
FacilityType					
OB/Gyn	☐	☐	☐	☐	
Internal Medicine/Family Practice	☐	☐	☐	☐	
Adult HIV specialty clinic	☐	☐	☐	☐	
County/Local Health Department	☐	☐	☐	☐	
Managed Care Organization (MCO) or Health	☐	☐	☐	☐	

Maintenance Organization (HMO)					
Community Health Center	☐	☐	☐	☐	
School or Work-based clinic	☐	☐	☐	☐	
Correctional facility	☐	☐	☐	☐	
Clinic in a hospital	☐	☐	☐	☐	
None documented	☐	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	☐	
Provider Type					
Nurse Practitioner	☐	☐	☐	☐	
Nurse Midwife	☐	☐	☐	☐	
Family Physician	☐	☐	☐	☐	
Obstetrician or Gynecologist	☐	☐	☐	☐	
Perinatologist	☐	☐	☐	☐	
HIV Specialist/ Infectious Disease Specialist	☐	☐	☐	☐	
Unknown/Not documented	☐	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	☐	

Additional comments: Please note any additional/clarifying comments for introductory information.

____

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Syphilis Testing

3) Do the patient's medical records document that she was diagnosed with syphilis prior to this pregnancy?

☐ Yes
☐ No

4) Documented syphilis testing prior to this pregnancy (please document one test per row; if two or more tests were performed on the same date, document each test on its own row with the same date):

☐ No testing documented (skip to #6)

Date testing offered	Test type (treponemal test, nontreponemal test, or darkfield microscopy), or refusal of testing	Type of non/treponemal test (e.g., RPR, VDRL, EIA, TP-PA) (if applicable)	Test Result (include titer, if available)	Date communicated to patient

5) Indicate the type of provider making the diagnosis and the location of the diagnosis.

Type of Provider	Location of Diagnosis
☐ Nurse Practitioner	☐ Private Provider's office
☐ Nurse Midwife	☐ County or City Health Department *(specify)*: __________________
☐ Family Physician/Internist	☐ Managed Care Organization
☐ Obstetrician	☐ Clinic in a hospital
☐ Perinatologist	☐ Hospital emergency room, other episodic/as needed care provider
☐ HIV Specialist/ID Specialist	☐ Community Health Center
☐ Other *(specify)*: __________________	☐ Other *(specify)*: __________________
☐ Unknown/Not Documented	☐ Unknown/Not Documented

Additional comments: Please note any additional/clarifying comments related to syphilis testing prior to this pregnancy.

____

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Syphilis Treatment Prior to Pregnancy

6) Is there documentation of treatment for syphilis prior to this pregnancy?

☐ Yes *(complete table)*
☐ No *(skip to Preconception Health Risk Factors section)*

Drug Name	Date Given	Dosage
I.	_______/_______/____________	
II.	_______/_______/____________	
III.	_______/_______/____________	
IV.	_______/_______/____________	
V.	_______/_______/____________	
VI.	_______/_______/____________	
VII.	_______/_______/____________	
VIII.	_______/_______/____________	

Additional comments: Please note any additional/clarifying comments related to syphilis care prior to this pregnancy.

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Preconception Health Risk Factors Prior to Pregnancy

7) Is there evidence of the following preconception health risk factors? Check all that apply.

☐ No evidence of preconception health risk factors.

Risk Factor	Assessed	A Problem was Identified	Intervention or referral done	Comments
Cardiovascular Disease				
Bacterial Endocarditis	☐ Yes	☐ Yes	☐ Yes	
Arryhthmia	☐ Yes	☐ Yes	☐ Yes	
Congestive heart failure	☐ Yes	☐ Yes	☐ Yes	
DVT (deep vein thrombosis)	☐ Yes	☐ Yes	☐ Yes	
MVP (mitral valve prolapse)	☐ Yes	☐ Yes	☐ Yes	
PE (pulmonary embolism)	☐ Yes	☐ Yes	☐ Yes	
Hypertension	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Urologic Disease				
Urinalysis/Urine culture	☐ Yes	☐ Yes	☐ Yes	
Acute Pyelonephritis	☐ Yes	☐ Yes	☐ Yes	
Renal Disease	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Endocrinologic/Metabolic				
Thyroid (specify in comments)	☐ Yes	☐ Yes	☐ Yes	
Diabetes (specify class in comments)	☐ Yes	☐ Yes	☐ Yes	

Hypergycemia	☐ Yes	☐ Yes	☐ Yes	
Adrenal: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Pituitary: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Maternal phenylketonurea (PKU)	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Respiratory Disease				
Active Tuberculosis	☐ Yes	☐ Yes	☐ Yes	
Asthma	☐ Yes	☐ Yes	☐ Yes	
Pneumococcal infection	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Neuro/psychiatric				
Psychiatric illness (specify)	☐ Yes	☐ Yes	☐ Yes	
Seizure disorder	☐ Yes	☐ Yes	☐ Yes	
Hx of perinatal related depression	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Hematologic				
Folic acid deficiency	☐ Yes	☐ Yes	☐ Yes	
Rh Sensitized	☐ Yes	☐ Yes	☐ Yes	
Hemolytic anemia	☐ Yes	☐ Yes	☐ Yes	
Iron deficiency anemia	☐ Yes	☐ Yes	☐ Yes	
Sickle cell disease	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Hepatic				
Cirrhosis	☐ Yes	☐ Yes	☐ Yes	
Hepatitis A	☐ Yes	☐ Yes	☐ Yes	
Hepatitis B	☐ Yes	☐ Yes	☐ Yes	
Hepatitis C	☐ Yes	☐ Yes	☐ Yes	
Hepatoxicity	☐ Yes	☐ Yes	☐ Yes	
Pancreatitis	☐ Yes	☐ Yes	☐ Yes	
Cholecystitis	☐ Yes	☐ Yes	☐ Yes	
Ulcer: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Inflammatory Bowel Disease	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Trauma/physical injury				
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Immunologic				
Atypical Antibody Screen	☐ Yes	☐ Yes	☐ Yes	
ITP/TTP	☐ Yes	☐ Yes	☐ Yes	
Arthritis	☐ Yes	☐ Yes	☐ Yes	
Systemic lupus erythematosus	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
STIs				
Pap test	☐ Yes	☐ Yes	☐ Yes	
Chlamydia trachomatis	☐ Yes	☐ Yes	☐ Yes	
Neisseria gonorrhoeae	☐ Yes	☐ Yes	☐ Yes	
Condylomata acuminata (genital warts)	☐ Yes	☐ Yes	☐ Yes	
Herpes simplex virus	☐ Yes	☐ Yes	☐ Yes	
Treponema pallidum (syphilis)	☐ Yes	☐ Yes	☐ Yes	
Trichimonas	☐ Yes	☐ Yes	☐ Yes	

Human Papillomavirus (specify in comments)	☐ Yes	☐ Yes	☐ Yes	
Other STI (specify)	☐ Yes	☐ Yes	☐ Yes	
Infectious Diseases				
HIV/AIDS	☐ Yes	☐ Yes	☐ Yes	
Rubella seronegativity	☐ Yes	☐ Yes	☐ Yes	
Influenza	☐ Yes	☐ Yes	☐ Yes	
Varicella	☐ Yes	☐ Yes	☐ Yes	
Group B strep	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Substance Abuse				
Toxicology screen	☐ Yes	☐ Yes	☐ Yes	
Alcohol use	☐ Yes	☐ Yes	☐ Yes	
Nicotine/tobacco	☐ Yes	☐ Yes	☐ Yes	
Crack	☐ Yes	☐ Yes	☐ Yes	
Cocaine	☐ Yes	☐ Yes	☐ Yes	
Crystal meth (methamphetamine)	☐ Yes	☐ Yes	☐ Yes	
Heroin	☐ Yes	☐ Yes	☐ Yes	
Opiates	☐ Yes	☐ Yes	☐ Yes	
Marijuana or hashish	☐ Yes	☐ Yes	☐ Yes	
PCP, angel dust, LSD	☐ Yes	☐ Yes	☐ Yes	
Speed/uppers	☐ Yes	☐ Yes	☐ Yes	
Methadone	☐ Yes	☐ Yes	☐ Yes	
Drug use but unknown type	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	
Were any of the above substances injected? ☐ No ☐ Yes (specify in comments column) ☐ Unknown				
Other Risk Factors				
Anti-epileptic drugs	☐ Yes	☐ Yes	☐ Yes	
Obesity	☐ Yes	☐ Yes	☐ Yes	
Oral anticoagulant	☐ Yes	☐ Yes	☐ Yes	
Isotretinoins	☐ Yes	☐ Yes	☐ Yes	
Other maternal health condition (specify): ______________________________	☐ Yes	☐ Yes	☐ Yes	

8) Please list any medications noted in the records that the woman was taking prior to pregnancy.

____

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Additional comments: Please note any additional/clarifying comments related to additional preconception care, health risk factors and family planning used prior to this pregnancy.

____

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Preconception Care and Family Planning

9) Is there documentation that the woman received specific preconception counseling before she became pregnant?

☐ Yes
☐ No

10) Indicate all family planning methods the woman was using and/or prescribed or recommended in the year prior to pregnancy. *(check all that apply)*

☐ Chart does not indicate if contraception was used prior to pregnancy.

Method	Using	Prescribed or Recommended	Comments
Abstinence	☐ Yes	☐ Yes	
Traditional Methods			
Withdrawl	☐ Yes	☐ Yes	
Fertility Awareness Method (FAM)	☐ Yes	☐ Yes	
Lactational Amenorrhea Method (LAM)	☐ Yes	☐ Yes	
Barrier Methods			
Male Condom	☐ Yes	☐ Yes	
Female Condom	☐ Yes	☐ Yes	
Diaphragm	☐ Yes	☐ Yes	
Cervical Cap	☐ Yes	☐ Yes	
Contraceptive Sponge	☐ Yes	☐ Yes	
Hormonal Methods			
Mirena Intrauterine Device (IUD)	☐ Yes	☐ Yes	
Implant (Implanon)	☐ Yes	☐ Yes	
Patch (OrthoEvra)	☐ Yes	☐ Yes	
Injection (Depo-Provera)	☐ Yes	☐ Yes	
Vaginal Ring (NuvaRing)	☐ Yes	☐ Yes	
Oral Contraceptive (specify): ____________	☐ Yes	☐ Yes	
Emergency Contraception	☐ Yes	☐ Yes	

Non-Hormonal Methods			
ParaGard Intrauterine Device (IUD)	☐ Yes	☐ Yes	
Male Sterilization	☐ Yes	☐ Yes	
Other			
Specify:_________	☐ Yes	☐ Yes	
Sterilization		**Scheduled for:**	**Comments**
Female tubal ligation	☐ Yes	__/__/____	
Female hysterectomy	☐ Yes	__ /__/____	

Additional comments: Please note any additional/clarifying comments related to additional preconception care, health risk factors and family planning used prior to this pregnancy.

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Hospitalization and Emergency Room Visits

11) List hospital visits or emergency department visits *during the year prior to pregnancy.*

☐ No documented hospital or ER visits during the year prior to pregnancy (*skip to 13*).

Visit	Date of Admission	Date of discharge	Type of hospital visit	Admission diagnosis	Discharge Diagnoses	HIV status was documented?	Treatment
1	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes ☐ No	
2	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes ☐ No	
3	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes ☐ No	

11a) Is there documentation that the woman was subsequently referred to another provider?

☐ Yes *(specify for what diagnosis and to whom)*__________________________________

____

☐ No

12) List significant outcomes of hospitalizations and/or ER visits:

____

____

____

Additional comments: Please note any additional/clarifying comments related to woman's hospitalization and emergency room visits prior to pregnancy.

____

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Stressors, Violence, Social Support & Case Management Prior to this Pregnancy

13) Was there documentation that a social worker or case manager saw the mother in the year prior to this pregnancy?

☐ Yes
☐ No
☐ Unknown/Undocumented

13a) Did medical, nursing or social work personnel identify any of the problems listed below *in the year prior* to this pregnancy? (check all that apply) Indicate whether a case management plan was developed for identified problems.

☐ No problems identified in the year prior to pregnancy (*skip to 13c*).

Problem	Documented prior to this pregnancy	Case management plan developed	Was this a Ryan White case management resource?
Disturbed relationship with other child/children	☐	☐	☐ Yes
Depression	☐	☐	☐ Yes
Inadequate support systems	☐	☐	☐ Yes
Housing inadequate/homeless	☐	☐	☐ Yes
Need for Public Assistance, Medicaid, Food Stamps, WIC, or	☐	☐	☐ Yes

other financial support			
Physical assault by any partner	☐	☐	☐ Yes
Threats, restriction of movement or contacting other people by any partner	☐	☐	☐ Yes
Forced sex	☐	☐	☐ Yes
Substance abuse	☐	☐	☐ Yes
Mother abused as child	☐	☐	☐ Yes
Drug/EtOH abuse (mother/partner)	☐	☐	☐ Yes
Employment/education needs (mother/partner)	☐	☐	☐ Yes
Crime/legal problems (mother/partner)	☐	☐	☐ Yes
Lack of transportation	☐	☐	☐ Yes
Teen mother	☐		
Single mother	☐		
Other *(specify)*:___________________________	☐	☐	☐ Yes

13b) What treatments were documented for these problems?

1 ____
2 ____
3 ____
4 ____
5 ____

☐ None
☐ Unknown/Not documented

13c) Is there documentation of referral(s) for any support services in the year prior to pregnancy? (Check all that apply)

☐ No referrals for support services were documented in the year prior to pregnancy

Referral Type	
☐ Financial Planning	
☐ WIC	
☐ Food Stamps	
☐ Housing Authority	
☐ Group Shelter	
☐ Smoking Cessation Program	
☐ Alcohol Treatment Program	
☐ Methadone Maintenance Program	
☐ Other Drug Treatment Program	
☐ Genetic evaluation counseling	
☐ Medicaid	
☐ Unemployment Office	
☐ Child Protective Services	

☐ GED programs	
☐ Legal aid	
☐ Physically handicapped child program	
☐ Infant/child health program	
☐ Home technology (ie photo therapy, etc.)	
☐ Partner counseling and referral services	
	Was this a Ryan White resource?
☐ PHN Home Assessment/Follow-up	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Homemaker/Home health aide	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Mental Health Services	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Clinical Case Management (e.g. Healthy Start)	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Ongoing Social Work Case Management	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Family Planning	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Other (*specify*):	☐ Yes ☐ No ☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to stressors, social support, case management, etc. prior to this pregnancy.

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Additional Comments

Use this space to record any other information that might be of interest for this review.

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This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the American College of Obstetricians and Gynecologists (the College), City**M**at**CH**, and the National Fetal and Infant Mortality Review Program (NFIMR).

FIMR/HIV PREVENTION METHODOLOGY
NATIONAL RESOURCE CENTER

Pregnancy-Related Care Record

Case Number: ______________________

Abstraction Completion Date: ___/___/___

1) This form collects information relating to the medical care received during the woman's pregnancy. Please indicate the sources used to complete this form (check all that apply):
- ☐ Prenatal Care Record
- ☐ HIV Care Record
- ☐ Hospitalization Record
- ☐ Health Department Record
- ☐ Other (*specify*): ______________________
- ☐ Other (*specify*): ______________________

Language Barriers and Translation Services

2) Was the woman's primary language something other than English?
- ☐ Yes *(specify)*:____
- ☐ No (*Skip to additional comments of this section)*
- ☐ Unknown/Not documented

2a) If yes, were language services provided?
- ☐ Yes (specify in which clinical or service setting): ________________________________
- ☐ No *(specify why not)*:____
- ☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments regarding language barriers and translation services during this pregnancy.

____

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Prenatal Care Information

3) What was the payor source at registration for prenatal care? *(check all that apply)*
- ☐ Private insurance
- ☐ Managed care organization (MCO) or Health maintenance organization (HMO), private payor
- ☐ Traditional Medicaid

☐ Medicaid Managed care organization (MCO) or Health maintenance organization (HMO)
☐ Medicaid, type unknown
☐ Medicare
☐ CHAMPUS/Military insurance
☐ Self-pay, but eligible for Medicaid
☐ Self-pay
☐ Other *(specify)*:____

4) For each type of care, indicate where the services were received and the provider type. (*check all that apply)*

	Prenatal Care	General primary care	HIV Care	Pre-existing Dx Follow-Up	Other care (specify)
Care not received	☐	☐	☐	☐	
Facility Type					
OB/Gyn Private Practice	☐	☐	☐	☐	
Internal Medicine/Family Practice Private Practice	☐	☐	☐	☐	
Adult HIV specialty clinic	☐	☐	☐	☐	
County/Local Health Department	☐	☐	☐	☐	
Managed Care Organization (MCO) or Health Maintenance Organization (HMO)	☐	☐	☐	☐	
Community Health Center	☐	☐	☐	☐	
Correctional facility	☐	☐	☐	☐	
Clinic in a hospital	☐	☐	☐	☐	
Unknown/Not Documented					
Other (specify): __________	☐	☐	☐	☐	
Other (specify): __________	☐	☐	☐	☐	
Provider Type					
General primary care provider (internal medicine physician, family physician, nurse practitioner, physician assistant)	☐	☐	☐	☐	☐
Nurse Midwife	☐	☐	☐	☐	☐
Family physician	☐	☐	☐	☐	☐
Obstetrician	☐	☐	☐	☐	☐
Perinatologist	☐	☐	☐	☐	☐
HIV Specialist/ID specialist	☐	☐	☐	☐	☐
Unknown/Not documented	☐	☐	☐	☐	☐
Other (specify): __________	☐	☐	☐	☐	☐

4a) Was the prenatal care provider also an HIV specialist?
☐ Yes
☐ No

Additional comments: Please note any other comments about the prenatal care received during this pregnancy.

____

____

Pregnancy Information

5) Please list the following relating to the woman's nutritional history.

		Gestational Age
Height	______cm	_______weeks
Weight (earliest)	_____kgm	_______weeks
Weight (latest)	_____kgm	_______weeks
BMI (earliest)	_________	_______weeks
BMI (latest)	_________	_______weeks
Was a nutritional assessment documented in the chart?	☐ Yes ☐ No	_______weeks
Was a referral to a dietitian ordered?	☐ Yes	_______weeks
Was the mother enrolled WIC?	☐ Yes	_______weeks

6) Does the chart indicate whether the pregnancy was intended?
☐ Yes, pregnancy was intended
☐ No, pregnancy was not intended and contraception was not used
☐ No, pregnancy was not intended and contraception was used
☐ Chart did not indicate pregnancy intention

7) What was the woman's age at registration for prenatal care?
_____________ years
☐ Unknown/Not documented

8) Weeks gestation at first prenatal care visit:

___________weeks
☐ Unknown/Not documented

9) Please document all ultrasounds obtained this pregnancy

Date	Trimester (first, second, or third)	Abnormal findings (if any)

9a) Was there any discrepancy in fetus size versus dates noted at any time during the pregnancy?

☐ Yes, specify____

9b) If a follow up ultrasound occurred, please record fetal weight and percentile:

____

☐ No

10) Weeks of gestation at last prenatal care visit prior to delivery: ___________weeks

☐ Unknown/Not documented

11) Number of prenatal care visits documented: (visits specifically for prenatal care) ____

12) Number of missed prenatal care visits documented: ________*(if 0, skip to next section)*

12a) If visits were missed, check documented methods used to follow-up on missed appointments: *(check all that apply)*
☐ Letter
☐ Telephone call
☐ Outreach worker/public health nurse home visit
☐ Not known

☐ No method of follow-up noted
☐ Other *(specify)*:____

Additional comments: Please note any additional/clarifying comments related to this pregnancy.

____

____

Obstetrical History & Pregnancy Outcomes

13) Please provide pregnancy history information below in reverse chronological order, most recent pregnancy first.

☐ Pregnancy history not available/unknown.

Pregnancy	Year of Delivery or Outcome	Gestational Age	Birth Weight	Pregnancy Outcome (See key below)	HIV Status	Comments/Complications
1					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
2					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
3					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
4					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
5					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
6					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
7					☐ Infected ☐ Uninfected ☐ Indeterminate ☐ Not Documented	
8					☐ Infected ☐ Uninfected ☐ Indeterminate	

					☐ Not Documented	

Pregnancy Outcome
A Live birth, still living
B Live birth, deceased
C Preterm
D Elective Abortion
E Spontaneous Abortion
F Ectopic
G IUFD

13a) Pregnancy History Summary

TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

14) Were maternal complications documented for any previous pregnancy? (*check all that apply)*

☐ Yes, pre-term labor
☐ Yes, cesarean-section
☐ IUFD (Intrauterine fetal demise)
☐ IUGR (intrauterine growth restriction)
☐ Yes, *(specify)*: ____
☐ No

Additional comments: Please note any additional/clarifying comments related to the pregnancy outcomes, including comments regarding deliveries (emergency c-section, etc.), as well as information regarding HIV status of other children.

____

____

Syphilis Testing

15) Do the patient's medical records document that she was diagnosed with syphilis prior to this pregnancy?

☐ Yes, diagnosis communicated to prenatal care provider by other health care provider
☐ Yes, diagnosis communicated to prenatal care provider by the patient
☐ Yes, diagnosis made by prenatal care provider prior to this pregnancy
☐ No

15a) Please specify stage (primary, secondary, latent, tertiary):__________________________

16) Please list documented syphilis testing <u>prior to this pregnancy</u>:

☐ No testing documented *(skip to next section)*

Date testing offered	Darkfield microscopy result, if applicable	Treponemal (e.g., EIA, TP-PA) test result, if applicable	Nontreponemal (e.g., RPR, VDRL) titer, if applicable	Date patient informed of result

16a) If testing done during pregnancy, indicate the type of provider making the diagnosis and the location of the diagnosis.

Type of Provider	**Location of Diagnosis**
☐ Nurse Practitioner	☐ Private Provider's office
☐ Nurse Midwife	☐ County or City Health Department *(specify)*: ___________________
☐ Family Physician/Internist	☐ Managed Care Organization
☐ Obstetrician	☐ Clinic in a hospital
☐ Perinatologist	☐ Hospital emergency room, other episodic/as needed care provider
☐ HIV Specialist/ID specialist	☐ Community Health Center
☐ Other *(specify)*: ___________________	☐ Other *(specify)*: __________________
☐ Unknown/Not Documented	☐ Unknown/Not Documented

16b) Please note any co-infection (HIV, hepatitis B or C, gonorrhea, chlamydia, chancroid, *Mycoplasma genitalium*) ____

<u>Additional comments: Please note any additional/clarifying comments related to HIV testing during this pregnancy.</u>

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____

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Syphilis Care

17) Is there documentation of testing for syphilis <u>during this pregnancy</u>?

☐ Yes
☐ No

Date testing offered	Darkfield microscopy result, if applicable	Treponemal (e.g., EIA, TP-PA) test result, if applicable	Nontreponemal (e.g., RPR, VDRL) titer, if applicable	Date patient informed of result

17a) Is there documentation of treatment for syphilis <u>during this pregnancy</u>?

☐ Yes *(complete table)*
☐ No *(skip to Pregnancy Complications section)*

Drug Name	Date Given	Dosage
I.	________/________/_____________	
II.	________/________/_____________	
III.	________/________/_____________	
IV.	________/________/_____________	
V.	________/________/_____________	
VI.	________/________/_____________	
VII.	________/________/_____________	
VIII.	________/________/_____________	

<u>Additional comments: Please note any additional/clarifying comments related to syphilis care prior to this pregnancy.</u>

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Pregnancy Complications, Comorbidities, and Health Risk Factors

18) Is there evidence of the following comorbidities or health risk factors? (*check all that apply)*

☐ No evidence of comorbidities or health risk factors

Risk Factor	Assessed	New Diagnosis	A Problem was Identified	Intervention or referral done	Comments
Obstetrical					
Degenerating myoma	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Incompetent cervix	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pre-eclampsia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Eclampsia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Placental abruption	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Placental previa	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pre-term labor	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Stillbirth	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Fetal Abnormalities					
Growth restriction	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Birth defects: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cardiovascular Disease					
Bacterial Endocarditis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Arrhythmia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cardiomyopathy	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Congestive heart failure	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
DVT (deep vein thrombosis)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
MVP (mitral valve prolapse)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
PE (pulmonary embolism)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hypertension	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Urologic Disease					
Urinalysis/Urine Culture	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Acute Pyelonephritis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Renal Disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Endocrinologic/Metabolic					
Thyroid (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Diabetes (specify class in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hyperglycemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Adrenal: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pituitary: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Maternal phenylketonurea (PKU)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Respiratory Disease					

Active Tuberculosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Latent Tuberculosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Asthma	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pneumonia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Neuro/psychiatric					
Psychiatric illness (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Seizure disorder	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hx of perinatal-related depression	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hematologic					
Folic acid deficiency	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Rh Sensitized	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hemolytic anemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Iron deficiency anemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Sickle cell disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Gastrointestinal/Hepatic					
Cirrhosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis A	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis B	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis C	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatoxicity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pancreatitis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cholecystitis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Ulcer: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Inflammatory Bowel Disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Trauma/physical injury					
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Immunologic					
Atypical Antibody Screen	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
ITP/TTP	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Arthritis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Systemic lupus erythematosus	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
STIs					
Pap Test	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Chlamydia trachomatis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Neisseria gonorrhoeae	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Condylomata acuminata (genital warts)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Herpes simplex virus	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Treponema pallidum (Syphilis)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Trichimonas	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Human Papillomavirus (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Infectious Diseases					
HIV/AIDS	☐ Yes	☐ Yes	☐ Yes	☐ Yes	

Rubella seronegativity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Influenza	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Varicella	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Group B strep	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Substance Abuse					
Toxicology Screen	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Alcohol	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Benzodiazepines	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Nicotine/tobacco	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Crack	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cocaine	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Crystal meth (methamphetamine)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Heroin	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Opiates	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Marijuana or hashish	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
PCP, angel dust, LSD, other hallucinogens	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Speed/uppers	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Methadone	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Drug use but unknown type	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Were any of the above substances injected? ☐ No ☐ Yes (specify in comments column) ☐ Unknown					
Other Risk Factors					
Obesity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Isotretinoins	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Oral anticoagulant	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Anti-epileptic drugs	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other maternal health condition (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	

Additional comments: Please note any additional/clarifying comments related to pregnancy complications, comorbidities, and other health risk factors.

____

____

____

Invasive Procedures

19) Were any of the following invasive procedures conducted during prenatal care? (*check all that apply*)

☐ Unknown/Not documented

Procedure	**Gestational age at time of procedure**
☐ Amniocentesis	________weeks
☐ Chorionic villus sampling	________weeks
☐ Other *(specify)*: _________________	________weeks

Additional comments: Please note any additional/clarifying comments related to invasive procedures during this pregnancy.

____

____

Hospitalization and Emergency Room Visits

20) List hospital visits or emergency department visits during this pregnancy.
☐ No documented hospital or ER visits during this pregnancy.

Visit	Date of Admission	Date of discharge	Type of hospital visit	Admission diagnosis	Discharge Diagnoses	HIV status was documented?	Treatment
1	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
2	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
3	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	

20a) Is there documentation that the woman was subsequently referred to another provider?
☐ Yes *(specify for what diagnosis and to whom)*____
____
☐ No

20b) List Significant Outcomes of hospitalizations and/or ER visits:

____

____

____

Additional comments: Please note any additional/clarifying comments related to the woman's hospitalization and emergency room visits during this pregnancy.

____

____

Health Education

21) At any time during this pregnancy were any of the following topics documented as having been discussed? *(check all that apply)*

☐ There were none documented

Topic	Discussed	Comments
How to avoid getting or transmitting HIV or other STDs / Safe sex	☐ Yes	
Importance of syphilis medicines for the woman's/fetus' health	☐ Yes	
Medication adherence/ treatment completion	☐ Yes	
Signs and symptoms of preterm labor and where to go for help	☐ Yes	
Medications or drugs that could affect your pregnancy	☐ Yes	
Family Planning / Plan for contraception	☐ Yes	
Finding a doctor or nurse practitioner to care for the baby	☐ Yes	
How smoking during pregnancy could affect the baby	☐ Yes	
How using alcohol (beer, wine, liquor) could affect your baby	☐ Yes	
Lactation suppression / infant feeding	☐ Yes	
Safe sleep/SIDS risk reduction activities	☐ Yes	
Rights and responsibilities of the pregnant woman	☐ Yes	
Partner counseling and referral services	☐ Yes	
Other topics documented (specify in comments)	☐ Yes	

Additional comments: Please note any additional/clarifying comments related to health education the woman received during this pregnancy.

____

____

Stressors, Violence, Mental Health, Social Support & Case Management

22) Did medical, nursing or social work personnel identify any of the problems listed below? Indicate whether a case management plan was developed for identified problems. *(check all that apply)*

☐ Chart does not indicate a problem during this pregnancy

Problem	Documented During pregnancy	Was a case management plan developed or in place?	Was this a Ryan White case management resource?
Disturbed relationship with other child/children	☐	☐	☐ Yes

Depression	☐	☐	☐ Yes
Inadequate support systems	☐	☐	☐ Yes
Housing inadequate/homeless	☐	☐	☐ Yes
Need for Public Assistance, Medicaid, Food Stamps, WIC, or other financial support	☐	☐	☐ Yes
Physical assault by any partner	☐	☐	☐ Yes
Threats, restriction of movement or contacting other people by any partner	☐	☐	☐ Yes
Forced sex	☐	☐	☐ Yes
Substance abuse	☐	☐	☐ Yes
Mother abused as child	☐	☐	☐ Yes
Drug/EtOH abuse (mother/partner)	☐	☐	☐ Yes
Employment/education needs (mother/partner)	☐	☐	☐ Yes
Crime/legal problems (mother/partner)	☐	☐	☐ Yes
Lack of transportation	☐	☐	☐ Yes
Other *(specify)*:________________	☐	☐	☐ Yes

22a) What ***treatments*** were documented for these problems?

1 ________________
2 ________________
3 ________________
4 ________________
5 ________________

☐ None
☐ Unknown/Not documented

23) Is there documentation of referral(s) for any support services during this pregnancy? *(check all that apply)*

☐ No referrals for support services were documented during this pregnancy.

Referral Type	
☐ Financial Planning	
☐ WIC	
☐ Food Stamps	
☐ Housing Authority	
☐ Group Shelter	
☐ Smoking Cessation Program	
☐ Alcohol treatment program	
☐ Methadone Maintenance Program	
☐ Other Drug Treatment Program	
☐ Medicaid	
☐ Unemployment Office	
☐ Child Protective Services	
☐ PHN Home Assessment/Follow-up	
☐ Homemaker/Home health aide	
	Was this a Ryan White resource?
☐ Mental Health Services	☐ Yes

	☐ No ☐ Unknown/Not documented
☐ Clinical Case Management (e.g. Healthy Start)	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Ongoing Social Work Case Management	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Family Planning	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Other (*specify*):	☐ Yes ☐ No ☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to stressors, violence, mental health, social support and case management, etc. during the pregnancy period.

___

___

Living or Incarceration History

24) Did the woman spend time in any of the following types of facilities during this pregnancy? *(check all that apply)*

☐ Woman did not spend time at any of these facilities during this pregnancy.

Prison/Correctional Facility	☐ Yes	☐ No	☐ Unknown
Mental Health Facility	☐ Yes	☐ No	☐ Unknown
Drug Treatment Center	☐ Yes	☐ No	☐ Unknown
Battered Women's Shelter	☐ Yes	☐ No	☐ Unknown
Homeless Shelter	☐ Yes	☐ No	☐ Unknown
Home for Pregnant Teens	☐ Yes	☐ No	☐ Unknown
Other (specify): ___________	☐ Yes	☐ No	☐ Unknown

Additional comments: Please note additional/clarifying comments regarding living or incarceration history during this pregnancy.

___

___

Additional Comments

Use this space to record any other information that might be of interest for this review.

This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the American College of Obstetricians and Gynecologists (the College), City**M**at**CH**, and the National Fetal and Infant Mortality Review Program (NFIMR).

Delivery and Newborn Hospitalization Record

Case Number: _________
Abstraction Completion Date: __/__/____

Introductory Information

1) This form collects information relating to the medical care received during the woman's admission to L&D and immediate post-partum care of the infant. Please indicate the sources used to complete this form (check all that apply):
   - ☐ Pediatric outpatient care record
   - ☐ Maternal HIV care record (if applicable)
   - ☐ Pediatric hospitalization record
   - ☐ Infant NICU record
   - ☐ Maternal L&D Hospitalization record
   - ☐ Other (*specify*): ______________________

2) What is the woman's country of birth?
   - ☐ United States
   - ☐ Outside the United States (specify)____
   - ☐ Unknown/Not documented

3) Was the woman's primary language something other than English?
   - ☐ Yes *(specify)*:____
   - ☐ No (*skip to #4*)
   - ☐ Unknown/Not documented (*skip to #4*)

   3a) If yes, were language services provided?
   - ☐ Yes
   - ☐ No *(specify why not)*:____
   - ☐ Unknown/Not documented

4) What is the woman's date of birth: ___/___/_____
   - ☐ Unknown/Not documented

5) What is the woman's race/ethnicity:

   Ethnicity (select one)
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino

   Race (select one or more)
   - ☐ American Indian or Alaska Native
   - ☐ Asian

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

6) What was the payor source for the delivery? *(check all that apply)*
☐ Private insurance
☐ Managed care organization (MCO) or Health maintenance organization (HMO), private payor
☐ Traditional Medicaid
☐ Medicaid Managed care organization (MCO) or Health maintenance organization (HMO)
☐ Medicaid, type unknown
☐ Medicare
☐ TriCare/Military insurance
☐ Self pay, but eligible for Medicaid
☐ Self pay
☐ Other *(specify)*:____

7) Was the woman accompanied by a support person during labor and delivery?
☐ Yes (specify relationship to woman):____
☐ No

8) What was the location of the birth?
☐ Labor and Delivery
☐ Emergency Department
☐ Ambulance
☐ Outside hospital
☐ Home
☐ Unknown/Not documented

9) Is there indication that the woman had a birth plan?
☐ Yes
☐ No

Additional comments: Please note any other comments regarding introductory information.

____

____

Maternal Labor & Delivery and Postpartum Care

10) Time of admission ____:____ (24 hour clock)

11) Maternal status on admission
☐Blood pressure _____________/_____________
☐Pulse ___________________________
☐Respirations ___________________________
☐Temperature _____________C_

☐Cervical Dilation ___________ cm
☐Membranes ruptured ☐ Yes ☐No
☐Frequency of contractions ☐ Q _________ min ________sec
☐Duration of contractions ___________min _________sec

12) Fetal heart rate on admission: Infant A ________ Infant B _______ Infant C ________

13) Continued labor status
☐ None
☐ Spontaneous
☐ Induced
☐ Augmented

14) Labor duration: First Stage
☐ Normal (3-20 hrs)
☐ Abnormal (<3 hrs, >20 hrs)
☐ Unknown

15) Labor duration: Second Stage
☐ Normal (3-20 hrs)
☐ Abnormal (<3 hrs, >20 hrs)
☐ Unknown

16) List any medications noted in the records that the woman was taking when she presented for delivery.
☐ Woman was not taking any medication.

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

17) Was the prenatal care record available during hospitalization for labor and delivery?
☐ Yes
☐ No

18) Pregnancy, Syphilis Testing, and Syphilis Treatment Histories

TOTAL PREG	FULL TERM	PREMATURE	Abortion INDUCED	Abortion SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

Testing History

Date testing offered	Test type (treponemal test, nontreponemal test, or darkfield microscopy), or refusal of testing	Type of non/treponemal test (e.g., RPR, VDRL, EIA, TP-PA) (if applicable)	Test Result (include titer, if available)	Date communicated to patient

19) Mother's stage of syphilitic infection (primary, secondary, etc.): ______________________________

20) Mother's non-treponemal titer (closest to delivery, either during pregnancy or during admission for delivery):

1:__ __ __ __

21) Mother received her first dose of benzathine penicillin 30 or more days prior to delivery:

☐ Yes ☐ No ☐ unknown

22) Treatment History

Drug Name	Date Given	Dosage
I.	________/________/_____________	
II.	________/________/_____________	
III.	________/________/_____________	
IV.	________/________/_____________	
V.	________/________/_____________	

VI.	________/________/_____________	
VII.	________/________/_____________	
VIII.	________/________/_____________	

23) Mother completed treatment with benzathine penicillin that began 30 or more days prior to delivery:

☐ Yes ☐ No ☐ unknown

24) Are significant medical or obstetric problems present during this pregnancy documented in the labor and delivery record?

☐ Yes (specify) ____

☐ No

25) Did the woman develop any significant medical or obstetric problems during this labor and delivery or in the postpartum period? *(check all that apply)*

Cardiovascular		**Urinary Tract**	
☐	Hypertension	☐	Cystitis
☐	Hypotension	☐	Pyelonephritis
☐	Other (specify):______________________________	☐	Other (specify):______________________________
Endocrinologic/Metabolic		**Obstetric Problems**	
☐	Diabetes (specify class):_______________________	☐	Abnormal placenta or cord (specify):____________
☐	Pregnancy related (specify):___________________	☐	Macrosomia
☐	Thyroid (specify):______________________________	☐	Abruption
☐	Other (specify):______________________________	☐	Malpresentation
Gastrointestinal		☐	Accreta/Percreta
☐	Hepatitis (specify):____________________________	☐	Manual removal of retained placenta
☐	Liver failure	☐	Amniotic fluid embolism
☐	Other (specify):______________________________	☐	Multiple pregnancy
Hematologic		☐	Cervical/Vaginal laceration
☐	Nonuterine hemorrhage	☐	Oligohydramnios
☐	HELLP syndrome	☐	Chorioamnionitis
☐	Other (specify):______________________________	☐	Polyhydramnios
Infection		☐	Cord accident
☐	Fetal sepsis	☐	Post maturity
☐	Maternal sepsis	☐	Failure to progress
☐	Group B strep	☐	Previa
☐	Genital herpes	☐	Fetal demise
☐	Other STI (specify):___________________________	☐	Pregnancy induced hypertension/Pre-eclampsia
☐	Other (specify):______________________________	☐	Fetal distress
Neurologic/Psychiatric		☐	Premature labor
☐	Drug withdrawl symptoms (specify):_____________	☐	Fetal growth retardation
☐	Eclampsia relate seizures	☐	Previous C-section
☐	Emotional disorder (specify):__________________	☐	Force dystocia

☐	Other (specify):______________________________	☐	Uterine rupture
Respiratory		☐	Gross meconium
☐	Asthma	☐	4 ° Extension of episiotomy
☐	Pneumonia	☐	Hemorrhage (>500cc)
☐	Other (specify):______________________________	☐	Other (specify):______________________________
Trauma/Physical Injury			
☐	Specify:____________________________________		

26) Was the woman referred to any other providers for medical consultation during labor and delivery? *(check all that apply)*

☐ Perinatologist
☐ HIV specialist/Infectious disease specialist
☐ Other (specify):____

27) Indicate if the woman received any anesthesia during labor and delivery. *(check all that apply)*

☐ No anesthesia
☐ Unknown/Not documented

Type	Date first administered	(24 hour time)
☐ Epidural / spinal	_____/_____/_____	______:______
☐ Local/pudendal	_____/_____/_____	______:______
☐ IV narcotic *(specify)*_______________	_____/_____/_____	______:______
☐ General	_____/_____/_____	______:______

28) Is there documentation that maternal drugs were administered during labor and delivery? *(check all that apply)*

☐ No drugs administered
☐ Oxytocin (Pitocin)
☐ Misoprostil (Cytotec)
☐ Prostin gel
☐ Magnesium Sulfate ($MgSO_4$)
☐ Corticosteroids (betamethasone/ dexamethasone)
☐ Other tocolytic agents (i.e. Terbutaline/Brethine, Nifedipine)
☐ Antibiotics (specify):____

28a) What were the indications for the antibiotics? *(check all that apply)*

☐ Chorioamnionitis
☐ Group B Streptococcal (GBS) prevention
☐ C-section prophylaxis
☐ Other *(specify)*____
☐ Unknown/Not documented

29) Is there documentation of the following procedures during labor? (*check all that apply)*

☐ None of these procedures
☐ Intrauterine catheter (IUPC)
☐ Fetal scalp electrode (FSE/ISE)
☐ Fetal scalp blood sampling (scalp pH)
☐ Fetal pulse oximetry

☐ Mechanical dilation of cervix (laminaria, foley catheter)

30) Was the woman referred to any other providers for medical consultation during the postpartum hospital stay? *(check all that apply)*

☐ Perinatologist
☐ HIV specialist/Infectious disease specialist
☐ Pediatrician
☐ Other (specify):____

31) If the woman did not receive prenatal care, was a notation made of the woman's reason(s) for not seeking services? *(check all that apply)*

☐ Not applicable, woman received prenatal care.
☐ Financial
☐ Limited/absent availability of service
☐ Other (specify): ____
☐ No notation found

32) What was the duration of postpartum stay? ________ hours

33) If the infant died, is there any documentation of counseling or bereavement support for the woman?

☐ Yes (specify): ____
☐ No
☐ Unknown/Not documented
☐ Not applicable

34) Is a maternal discharge plan documented in the records?

☐ Yes
☐ No
☐ Unknown/Not documented

35) Was a postpartum follow-up visit scheduled for the mother?

☐ Yes
☐ No (*skip to #36*)
☐ Woman instructed to call to make an appointment (*skip to #36*)

35a) If yes, specify the location for postpartum visit.

☐ Clinic at hospital
☐ Community health center, county or city health department
☐ Hospital emergency room, other episodic or as needed care provider
☐ Managed care organization (MCO)
☐ Private provider's (MD, CNM) office
☐ Other (specify): ______________________________________

35b) How many weeks after the delivery was the visit scheduled? ________weeks

36) Was maternal HGB/HCT within normal limits at discharge?

☐ Yes
☐ No

☐ Unknown/Not documented

37) Were any postpartum complications documented prior to discharge? *(check all that apply)*

☐ None
☐ Endomyometritis
☐ Wound dehiscence
☐ Wound infection
☐ Mastitis
☐ Postpartum hemorrhage
  ☐ 500-1000 cc ☐ >1000 cc
☐ Other *(specify)*:________________
☐ Pneumonia
☐ Pyelonephritis
☐ Pulmonary Embolism
☐ DVT
☐ Drug withdrawal

38) Indicate all family planning methods the woman was prescribed or recommended at discharge. *(check all that apply)*

☐ Chart does not indicate if contraception was prescribed/recommended.

Method	Prescribed or Recommended	Comments
Abstinence	☐ Yes	
Traditional Methods		
Withdrawl	☐ Yes	
Fertility Awareness Method (FAM)	☐ Yes	
Lactational Amenorrhea Method (LAM)	☐ Yes	
Barrier Methods		
Male Condom	☐ Yes	
Female Condom	☐ Yes	
Diaphragm	☐ Yes	
Cervical Cap	☐ Yes	
Contraceptive Sponge	☐ Yes	
Hormonal Methods		
Mirena Intrauterine Device (IUD)	☐ Yes	
Implant (Implanon)	☐ Yes	
Patch (OrthoEvra)	☐ Yes	
Injection (Depo-Provera)	☐ Yes	
Vaginal Ring (NuvaRing)	☐ Yes	
Oral Contraceptive (specify): ______________	☐ Yes	
Emergency Contraception	☐ Yes	
Non-Hormonal Methods		
ParaGard Intrauterine Device (IUD)	☐ Yes	
Male Sterilization	☐ Yes	
Other		
Specify:_________	☐ Yes	
Sterilization	**Scheduled for:**	**Comments**
Female tubal ligation	__/__/____	

	☐ At L&D	
Female hysterectomy	__/__/____ ☐ At L&D	

39) List any other medications the woman was discharged with.
☐ Discharged with no medications

____________________________ ______________________________
____________________________ ______________________________
____________________________ ______________________________
____________________________ ______________________________

40) List the discharge diagnoses for the woman and the ICD-9 or ICD-10 codes:

☐ No discharge diagnoses documented.

	ICD-9 codes	ICD-10 codes

Additional comments: Please note any other comments regarding maternal labor and delivery and postpartum care.

____
____
____

Syphilis Testing and Care

41) Was there documentation of a previously established diagnosis of syphilis infection prior to admission to L&D?
☐ Yes
☐ No
Stage of syphilitic infection (primary, secondary, etc.): ______________________________

42) List documented syphilis testing during labor and delivery hospitalization.
☐ No testing documented (*skip to #43*)

Date and time testing offered (24 hour clock)	**Refusal or Type of Test**	**Test Result**	**Date result communicated to patient**
__/__/____ ____:_____	Testing refused		
__/__/____ ____:_____	darkfield microscopy	positive/negative	

__/__/________:_____	Polymerase chain reaction (PCR)	positive/negative	
__/__/____ ____:_____	non-treponemal test (RPR, VDRL, or equivalent)	reactive, nonreactive (if reactive, show titer)	
__/__/____ ____:_____	Treponemal test (EIA, CIA, TP-PA, or equivalent)(circle type of treponemal test)	reactive/nonreactive	

Stressors, Violence, Social Support & Case Management

43) Was there documentation that a social worker or case manager saw the mother?

☐ Yes
☐ No
☐ Unknown/Undocumented

Did medical, nursing or social work personnel identify any of the psychosocial or lifestyle problems listed below during the intrapartum period? Indicate whether a case management plan was developed for identified problems. *(check all that apply)*

☐ Chart does not indicate any problems

Problem	Identified During hospitalization	Was a case management plan developed?	Was this a Ryan White case management resource?
Disturbed relationship with other child/children	☐	☐	☐ Yes
Depression	☐	☐	☐ Yes
Inadequate support systems	☐	☐	☐ Yes
Housing inadequate/homeless	☐	☐	☐ Yes
History of abuse (other children)	☐	☐	☐ Yes
Need for Public Assistance, Medicaid, Food Stamps, WIC, or other financial support	☐	☐	☐ Yes
Physical assault by any partner	☐	☐	☐ Yes
Threats/restriction of movement or from contacting other people by any partner	☐	☐	☐ Yes
Physical/developmental handicap (mother/partner)	☐	☐	☐ Yes
Forced sex	☐	☐	☐ Yes
Mother abused as child	☐	☐	☐ Yes
Drug/EtOH abuse (mother/partner)	☐	☐	☐ Yes
Employment/education needs (mother/partner)	☐	☐	☐ Yes
Crime/legal problems (mother/partner)	☐	☐	☐ Yes
Lack of transportation	☐	☐	☐ Yes
Teen mother	☐	☐	☐ Yes
Chronic illness of the mother or infant requiring continuing medical care (physical or mental) *(specify)*:________________	☐	☐	☐ Yes
Other *(specify)*:________________	☐	☐	☐ Yes

43a) What ***treatments*** were documented for these problems?

____________________________ ________________________________
____________________________ ________________________________
____________________________ ________________________________

☐ None
☐ Unknown/Not documented

44) Is there documentation of referral(s) for any support services at any time during her hospital stay? *(check all that apply)*

☐ No referrals for support services were documented

Referral Type	
☐ Financial Planning	
☐ WIC	
☐ Food Stamps	
☐ Housing Authority	
☐ Group Shelter	
☐ Smoking Cessation Program	
☐ Alcohol Treatment Program	
☐ Methadone Maintenance Program	
☐ Other Drug Treatment Program	
☐ Genetic evaluation/counseling	
☐ Medicaid	
☐ Unemployment Office	
☐ Child Protective Services	
☐ GED programs	
☐ Legal aid	
☐ Physically handicapped child program	
☐ Infant/child health program	
☐ Home technology (ie photo therapy, etc.)	Specify:_________________________
	Was this a Ryan White resource?
☐ PHN Home Assessment/Follow-up	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Homemaker/Home health aide	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Mental Health Services	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Clinical Case Management (e.g. Healthy Start)	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Ongoing Social Work Case Management	☐ Yes

	☐ No ☐ Unknown/Not documented
☐ Family Planning	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Other (*specify*):	☐ Yes ☐ No ☐ Unknown/Not documented

Additional comments: Please note any other comments regarding maternal syphilis testing and care.

____
____
____

Health Education

45) At any time during the postpartum stay were any of the following topics documented in writing as having been discussed?

☐ There were none documented

Topic	Discussed	Comments
Importance of treating syphilis for the woman's own health	☐ Yes	
Transmitting HIV or other STDs	☐ Yes	
Family Planning/Child Spacing	☐ Yes	
Plan for contraception	☐ Yes	
Finding a doctor or nurse practitioner to care for the baby	☐ Yes	
How smoking could affect the baby	☐ Yes	
Infant feeding/Breastfeeding	☐ Yes	
Safe sleep/SIDS risk reduction activities	☐ Yes	
Partner counseling and referral services (PCRS)	☐ Yes	
Nutritional assessment	☐ Yes	
Maternal signs and symptoms that warrant medical attention	☐ Yes	
Infant signs and symptoms that warrant medical attention	☐ Yes	
Where to go for care in case of infant emergency	☐ Yes	
Where to go for care in case of maternal emergency	☐ Yes	
Bath safety	☐ Yes	
Small object avoidance	☐ Yes	
Use of infant car seat	☐ Yes	
Protection from falls	☐ Yes	
Shaken Baby Syndrome	☐ Yes	
Use of home smoke detector	☐ Yes	
Other:____	☐ Yes	
Other:____	☐ Yes	

Additional comments: Please note any other comments regarding health education.

____
____
____

Delivery Data on Infant

If woman delivered more than one infant, please duplicate the remainder of this form and complete for each infant

46) Type of pregnancy
- ☐ Singleton
- ☐ Twins
  - ☐ Infant A (1st born) ☐ Infant B (2nd born)
- ☐ Triplets
  - ☐ Infant A (1st born) ☐ Infant B (2nd born) ☐ Infant C (3rd born)
- ☐ Higher (specify):______________________

47) What was the fetal heart rate pattern during the last hour before delivery? *(check all that apply)*
- ☐ Normal (120-160/min) (*skip to #48*)
- ☐ Bradycardia (<120/min)
- ☐ Tachycardia (>160/min)
- ☐ Loss of baseline variability
- ☐ Late decelerations
- ☐ Variable decelerations

47a) If the heart rate was not normal, what intervention(s) is documented?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

48) Rupture of membranes
- ☐ Artificial Rupture of Membranes (AROM)
- ☐ Spontaneous Rupture of Membranes (SROM)
- ☐ Unknown/Not documented

49) Date and time of rupture of membranes

___/___/____

_____:_____ (24 hour clock)

50) Mode of delivery
- ☐ Forceps
- ☐ Repeat C-section
- ☐ Vacuum extraction
- ☐ Spontaneous vaginal delivery

☐ Primary C-section
☐ Other (specify):_______________________________

51) If the mother had a C-Section, forceps delivery, or vacuum extraction, what were the indications for that procedure? *(check all that apply)*

☐ None of these procedures were performed
☐ Non reassuring fetal status (fetal distress)
☐ Malpresentation (breech, transverse lie)
☐ Placenta previa/ abruption
☐ Hypertension/ preeclampsia
☐ Failure to progress/ failed induction/ arrest of descent
☐ Previous C-section
☐ HIV prevention (high viral load)
☐ Active genital herpes
☐ Cephalopelvic disproportion
☐ Dysfunctional contractions
☐ Prolonged rupture of membranes (PROM)
☐ Multiple gestation
☐ Macrosomia
☐ Patient choice
☐ Other:______________________
☐ Unknown/Not doc.

52) What time was the delivery? ____:____ (24 hour clock)

53) Apgar scores

☐ 1 minute __________
☐ 5 minutes _________
☐ 10 minutes _________

54) Birth weight at delivery _____________lbs___________oz____________grams

55) Gestational age at delivery _____________

56) Sex

☐ Female
☐ Male

57) If cord gases were done, please specify the results.

pH _____________
pCO2 ___________
pO2 ____________
Base Excess ________
☐ No cord gases done.

58) Were any neonatal resuscitation measures required/attempted in the delivery room? *(check all that apply)*

☐ No neonatal resuscitation in the delivery room
☐ Physical stimulation
☐ Bag and mask
☐ ET suction
☐ Intubation
☐ Respiratory meds
☐ Ext. cardiac massage
☐ Cardiac meds
☐ Other (specify): ___________________________

☐ Oxygen blow by: __________________________

58a) If assisted ventilation, was it:
☐ < 5 minutes
☐ > 5 minutes
☐ > 30 minutes

58b) Was surfactant treatment given in delivery room?
☐ Yes
☐ No

59) Describe any other infant problems not classified by above scheme?
☐ No other problems

____
____
____

<u>Additional comments: Please note any other comments regarding the delivery data on the infant.</u>

____
____
____

Newborn Assessment

60) Did the infant die at or during delivery?
☐ Yes
☐ No (*skip to #61*)

60a) What was the infant's date of death? _______/______/______
☐ Unknown/Not documented

60b) List the causes of death. (If autopsy/pathology is available, any exams for *T. pallidum* (special stains, etc.) – esp. of the cord and placenta – would be desirable. Other pathology data (liver, spleen, bones, etc.) would also be desirable.)

____________________________ ______________________________
____________________________ ______________________________
____________________________ ______________________________
☐ Unknown/Not documented

ENDS FORM IF Q60 = YES

61) Did the infant die post delivery?

☐ Yes, deceased before discharge after leaving delivery room
☐ Yes, deceased after discharge
☐ No (*skip to #62*)

61a) What was the infant's date of death? _______/______/______
☐ Unknown/Not documented

61b) List the causes of death. (If autopsy/pathology is available, any exams for *T. pallidum* (special stains, etc.) – esp. of the cord and placenta – would be desirable. Other pathology data (liver, spleen, bones, etc.) would also be desirable.)

___________________________ ______________________________
___________________________ ______________________________
___________________________ ______________________________

☐ Unknown/Not documented

62) Disposition from delivery room:

☐ Normal newborn nursery
☐ Rooming in
☐ Observation/special care nursery
☐ NICU at birth hospital
☐ NICU at other hospital
☐ Other (specify): ____

63) Were any birth defects noted during nursery stay?

☐ Yes (specify): ____
☐ No

64) Were any morbidities noted during nursery stay? *(check all that apply)*

☐ No morbidities documented during nursery stay
☐ Anemia due to fetal hemorrhage
☐ Hypothermia
☐ Delayed feeding adequacy
☐ Hypotonia
☐ Delayed transition
☐ Metabolic acidosis
☐ Drug withdrawal
☐ Perinatal asphyxia
☐ Convulsion
☐ Respiratory distress
☐ Hemolysis due to ☐ Rh ☐ ABO ☐ other
☐ Temperature instability
☐ Hyaline membrane disease
☐ Transient Tachypnea Newborn (TTN)
☐ Congenital CMV
☐ Neonatal HSV
☐ Congenital Toxo
☐ Congenital Syphilis
☐ Thrombocytopenia
☐ Hepatosplenomegaly
☐ Leukocytosis
☐ Leukopenia
☐ Rhinorrhea

☐ Hypoglycemia (<40) *(specify)*:_________________________________
☐ Jaundice *(Specify highest bilirubin level)*:__________________________________
☐ Neonatal sepsis *(Specify)*:_________________________________
☐ Perinatal STD exposure *(specify)*:_________________________________
☐ Perinatal STD infection *(specify)*:_________________________________
☐ Other *(specify)*:________________________

64a) If yes, please describe treatment:____
____

65) Were any birth injuries noted? *(check all that apply)*

☐ Bruising
☐ Peripheral nerve damage
☐ Cephalohematoma
☐ Fractures
☐ Lacerations
☐ Other (specify): ____
☐ No birth injuries noted

66) Was a urine toxicology done?

☐ Yes
☐ No (skip to #67)

66a) If results were positive, please specify which substances. *(check all that apply)*

☐ Alcohol
☐ Cocaine
☐ Amphetamines
☐ Heroine
☐ Barbiturates
☐ Methadone
☐ Cannabis
☐ Other (specify): __________________________________

67) Indicate if the following were administered *(check all that apply)*:

☐ Hepatitis B birth dose
☐ HBIg
☐ Erythromycin ointment
☐ Vitamin K injection
☐ None were administered

68) Was breastfeeding attempted?

☐ Yes
☐ No
☐ Unknown/Not documented

Infant Syphilis Testing and Care

69) List documented syphilis testing during the neonatal hospitalization period.

☐ No testing documented *(skip to #70)*

Date and time testing offered (24 hour clock)	Refusal or Type of Test	Test Result	Date result communicated to parent
__/__/____ ____:_____	Testing refused		
__/__/____	non-treponemal tests:	reactive (specify	

____:_____	RPR VDRL Equivalent test (USR, TRUST, etc.)	titer); non-reactive	
__/__/____ ____:_____	Treponemal tests: TP-PA EIA CIA Equivalent test (specify)	reactive; non-reactive	
__/__/____ ____:_____	Treponemal IgM immunoblot (NOT 19S FTA-ABS or EIA)	reactive/nonreactive	
__/__/____ ____:_____	Pertinent laboratory tests: CSF VDRL CSF protein and CSF WBC count	results (as applicable): CSF VDRL tier: CSF protein: CSF WBC count:	
__/__/____ ____:_____	Long bone X-ray exam	Consistent with CS; Not Consistent with CS	

70) List documented physical findings of the infant (check all that apply):

- ☐ No signs or symptoms noted
- ☐ Hepatosplenomegaly
- ☐ Jaundice/hepatitis
- ☐ Pseudo paralysis
- ☐ Edema
- ☐ Condyloma lata
- ☐ Hemorrhagic nasal discharge (“snuffles”)
- ☐ Syphilitic skin rash
- ☐ Other (specify) ____
- ☐ No physical exam noted

71) List documented syphilis treatment during the neonatal hospitalization period.

☐ No treatment documented Or Treatment Unknown *(skip to #72)*

Date and time treatment offered (24 hour clock)	**Refusal or Type of Treatment**	**Date penicillin was started (mm/dd/yyyy)**	**Date penicillin was discontinued (mm/dd/yyyy)**	**Reason why penicillin was discontinued (completed course, lost to follow up, etc.)**

__/__/____ ____:_____	Aqueous or Procaine penicillin for 10 days i.v. penicillin	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
__/__/____	Benzathine penicillinX1	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
	Other			

Infant Discharge Information

72) List any other medications prescribed for the infant to take after discharge from the hospital.

☐ Discharged with no medications

____________________________ ______________________________

____________________________ ______________________________

73) Were parents instructed in medication administration?

☐ Yes (specify): ____

☐ No

74) List the discharge diagnoses for the infant and the ICD-9 or ICD-10 codes:

	ICD-9 codes	ICD-10 codes

75) Nutrition at discharge

☐ Breastfeeding

☐ Formula

☐ Both

☐ Unknown/Not documented

76) Infant age at discharge? (in hours from delivery) _________ hours

☐ Unknown/Not documented

77) Was a discharge plan documented in the infant's records?

☐ Yes

☐ No

78) Infant disposition

☐ Transferred to NICU:

☐Same hospital ☐ Another hospital

☐ Transferred to regular nursery at another hospital

☐ Home with parents

☐ Discharged to public/private foster care

☐ Discharged to prospective adoptive parents

☐ Continued as boarder

☐ Other *(specify)*:____
☐ Unknown/Not documented

79) If transferred, list additional diagnoses given for the infant when discharged from the other hospital and the ICD-9 & ICD-10 codes.
☐ Unknown/Not documented

	ICD-9 codes	ICD-10 codes

80) What was the infant's age at discharge from other hospital? ______weeks

81) Was a follow-up pediatric visit scheduled for the infant?
☐ Yes
☐ No (skip to additional comments)
☐ Unknown/Not documented (skip to additional comments)

81a) If yes, specify the location for pediatric visit.
☐ Clinic at hospital
☐ Community health center, county or city health department
☐ Hospital emergency room, other episodic or as needed care provider
☐ Managed care organization (MCO)
☐ Private provider's (MD, CNM) office
☐ Other (specify): ______________________________________

81b) How many weeks after the delivery was the visit scheduled? ________weeks

<u>Additional comments: Please note any other comments regarding the infant's discharge.</u>

____
____
____

Additional Comments

Use this space to record any other information that might be of interest for this review.

____
____
____

____
____
____
____
____
____
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This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the Division of STD Prevention at CDC, the American College of Obstetricians and Gynecologists (the College), City**M**at**CH**, and the National Fetal and Infant Mortality Review Program (NFIMR).

Post-Pregnancy Care Records Abstraction Form
****Post-L&D Discharge through 12 months after delivery****

Case Number: ______________________

Abstraction Completion Date: ___/___/___ Abstractor: _______________________________

1) This form collects information relating to the health care the woman received after the delivery hospitalization. (check all that apply):
   ☐ PHN home visiting and/or other case management
   ☐ Routine postpartum OB/gyn care record.
   ☐ HIV care record.
   ☐ Hospitalization record.
   ☐ Other (*specify*): ______________________

Abstractor Please Note: For purposes of this form, questions refer to the post-pregnancy period of delivery discharge through 12 months after delivery unless otherwise specified as the 6-week post-partum period.

Introductory Information

2) For each type of care, indicate where the services were received and the provider type. (check all that apply)

	Gynecological/Family Planning Care	General primary care	HIV Care (if applicable)	Pre-existing Dx Follow-Up	Other care (specify)
Care not received	☐	☐	☐	☐	
Facility Type					
OB/Gyn Private Practice	☐	☐	☐	☐	
Internal Medicine/Family Practice Private Practice	☐	☐	☐	☐	
Adult HIV specialty clinic	☐	☐	☐	☐	
County/Local Health Department	☐	☐	☐	☐	
Managed Care Organization (MCO) or Health Maintenance Organization (HMO)	☐	☐	☐	☐	
Community Health	☐	☐	☐	☐	

Center					
Correctional facility	☐	☐	☐	☐	
Clinic in a hospital	☐	☐	☐	☐	
Unknown/Not Documented					
Other (specify): __________	☐	☐	☐	☐	
Other (specify): __________	☐	☐	☐	☐	
Provider Type					
General primary care provider (internal medicine physician, family physician, nurse practitioner, physician assistant)	☐	☐	☐	☐	☐
Nurse Midwife	☐	☐	☐	☐	☐
Obstetrician	☐	☐	☐	☐	☐
Perinatologist	☐	☐	☐	☐	☐
Unknown/Not documented	☐	☐	☐	☐	☐
Other (specify): __________	☐	☐	☐	☐	☐

Additional comments: Please note any additional/clarifying comments related to the introductory information.

____

____

Language Barriers and Translation Services

3) Was the woman's primary language something other than English?
☐ Yes *(specify)*:____
☐ No (*skip to #4*)
☐ Unknown/Not documented (*skip to #4*)

3a) If yes, were language services provided?
☐ Yes (specify in which clinical or service setting): ______________________
☐ No *(specify why not)*:______________________________________
☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to language barriers and translation services.

____

___

___

Home Visit

4) Did the woman receive a PHN home visit or other type of case management home visit during the 6-weeks post-partum period?
   - ☐ Yes
   - ☐ No

   4a) Were notes or other documentation of the PHN home visit shared with the mother's physician?
   - ☐ Yes
   - ☐ No

5) What was the purpose for the home visit(s)? ____

6) How many weeks postpartum were the visit(s)? ______________

7) Were there any concerns identified at the home visit? Specify:________________________________

8) Was this visiting service provided by Ryan White Funds?

☐Yes

☐No

☐ Unknown/Undocumented

Additional comments: Please note any additional/clarifying comments related to home visits for the post-partum period.

___

___

Postpartum Care

9) Did the woman receive routine postpartum care?

☐ Yes

☐ No (*skip to #15*)

☐ Unknown/Not documented (*skip to #15*)

   a) Location of postpartum care ____

10) How many weeks postpartum was the first visit? ___________

11) What was the payor source for postpartum care? *(check all that apply)*
☐ Private insurance
☐ Managed care organization (MCO) or Health maintenance organization (HMO), private payor
☐ Traditional Medicaid
☐ Medicaid Managed care organization (MCO) or Health maintenance organization (HMO)
☐ Medicaid, type unknown
☐ Medicare
☐ CHAMPUS/Military insurance
☐ Self pay, but eligible for Medicaid
☐ Self pay
☐ Other *(specify)*:________________________________

12) Was there documentation in the post-partum OB/gyn record that the woman was HIV positive?
☐ Yes
☐ No

13) Please list any medications noted in the postpartum OB/gyn records that the woman was taking during the post-pregnancy period. Include any information about prescriptions that the mother left the hospital with. Do not include contraceptives or ARVs.

____
____
____
____

14) Is there documentation that a second follow-up family planning/gynecological visit was scheduled?
☐ Yes
☐ No *(skip to #15)*
☐Woman instructed to call to make an appointment

14a) If yes, please specify facility type:
☐ Private Provider's office
☐ Adult HIV specialty clinic
☐ County/Local Health Department
☐ Managed Care Organization (MCO) or Health Maintenance Organization (HMO)
☐ Community Health Center
☐ Family Planning clinic (i.e. Planned Parenthood)
☐ Correctional facility
☐ Clinic at hospital
☐ Unknown/Not Documented
☐ Other (specify):________________________________

14b) When was the visit scheduled to take place?
☐ 3 months
☐ 6 months
☐ 1 year
☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to the woman's post-partum care.

____

____

Pregnancy Intention

15) Was there a discussion about future pregnancy intention documented in the chart?
☐ Yes, future pregnancy planned
☐ Yes, future pregnancy not intended *(skip to #16)*
☐ No (*skip to #17*)

15a) If a future pregnancy is planned, was timing of the next pregnancy discussed?
☐ Yes
☐ No
☐ Unknown/Undocumented

16) Which health care provider(s) discussed her future pregnancy intentions? (*check all that apply*)
☐ Nurse Practitioner
☐ Nurse Midwife
☐ Family Physician
☐ Obstetrician or Gynecologist
☐ Perinatologist
☐ HIV Specialist/Infectious Disease Specialist
☐ Unknown/Not documented
☐ Other *(specify)*:____

17) Indicate all family planning methods the woman was using and/or prescribed or recommended. *(check all that apply)*

☐ Record does not indicate if contraception is being used or prescribed

Method	**Using**	**Prescribed or Recommended**	**Comments**
Abstinence	☐ Yes	☐ Yes	
Traditional Methods			
Withdrawl	☐ Yes	☐ Yes	
Fertility Awareness	☐ Yes	☐ Yes	

Method (FAM)			
Lactational Amenorrhea Method (LAM)	☐ Yes	☐ Yes	
Barrier Methods			
Male Condom	☐ Yes	☐ Yes	
Female Condom	☐ Yes	☐ Yes	
Diaphragm	☐ Yes	☐ Yes	
Cervical Cap	☐ Yes	☐ Yes	
Contraceptive Sponge	☐ Yes	☐ Yes	
Hormonal Methods			
Mirena Intrauterine Device (IUD)	☐ Yes	☐ Yes	
Implant (Implanon)	☐ Yes	☐ Yes	
Patch (OrthoEvra)	☐ Yes	☐ Yes	
Injection (Depo-Provera)	☐ Yes	☐ Yes	
Vaginal Ring (NuvaRing)	☐ Yes	☐ Yes	
Oral Contraceptive (specify): ____________	☐ Yes	☐ Yes	
Emergency Contraception	☐ Yes	☐ Yes	
Non-Hormonal Methods			
ParaGard Intrauterine Device (IUD)	☐ Yes	☐ Yes	
Male Sterilization	☐ Yes	☐ Yes	
Other			
Specify:_________	☐ Yes	☐ Yes	
Sterilization	**Performed at L&D**	**Scheduled for:**	**Comments**
Female tubal ligation	☐ Yes	__/__/____	
Female hysterectomy	☐ Yes	__ /__/____	

Additional comments: Please note any additional/clarifying comments related to the woman's pregnancy intention.

____

____

Syphilis Care

18) Was there documentation of a previously established diagnosis of syphilis infection prior to delivery of the infant being investigated?

☐ Yes
☐ No

19) Documented syphilis testing during the post-partum period:

☐ No testing documented (*skip to # 20*)

Date testing offered	Test type (treponemal test, nontreponemal test, or darkfield microscopy), or refusal of testing	Type of non/treponemal test (e.g., RPR, VDRL, EIA, TP-PA) (if applicable)	Test Result (include titer, if available)	Date communicated to patient

20) Documented syphilis treatment during the post-partum period:

Drug Name	Date Given	Dosage
I.	_______/_______/___________	
II.	_______/_______/___________	
III.	_______/_______/___________	
IV.	_______/_______/___________	
V.	_______/_______/___________	
VI.	_______/_______/___________	
VII.	_______/_______/___________	
VIII.	_______/_______/___________	

Follow up of Pre-existing Conditions Comorbidities and Health Risk Factors

21) List the discharge diagnoses from the labor and delivery record (generated by data system or see Delivery Hospitalization Record).

Diagnoses	Follow-up Documented	Comments
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

22) Is there evidence of the following comorbidities or health risk factors? (*Check all that apply*).

☐ No evidence of preconception health risk factors

Risk Factor	Assessed	New Diagnosis	A Problem was Identified	Intervention or referral done	Comments
Cardiovascular Disease					
Bacterial Endocarditis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Arrhythmia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Congestive heart failure	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
DVT (deep vein thrombosis)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
MVP (mitral valve prolapse)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
PE (pulmonary embolism)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hypertension	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Urologic Disease					
Urinalysis/Urine Culture	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Acute Pyelonephritis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Renal Disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Endocrinologic/Metabolic					
Thyroid (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Diabetes (specify class in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hyperglycemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Adrenal: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pituitary: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Maternal phenylketonurea (PKU)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Respiratory Disease					
Active Tuberculosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Latent Tuberculosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Asthma	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pneumonia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Neuro/psychiatric					
Psychiatric illness (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Seizure disorder	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hx of perinatal-related depression	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hematologic					

Folic acid deficiency	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Rh Sensitized	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hemolytic anemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Iron deficiency anemia	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Sickle cell disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Gastrointestinal/Hepatic					
Cirrhosis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis A	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis B	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatitis C	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Hepatoxicity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Pancreatitis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cholecystitis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Ulcer: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Inflammatory Bowel Disease	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Trauma/physical injury					
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Immunologic					
Atypical Antibody Screen	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
ITP/TTP	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Arthritis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Systemic lupus erythematosus	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
STIs					
Pap Test	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Chlamydia trachomatis	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Neisseria gonorrhoeae	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Condylomata acuminata (genital warts)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Herpes simplex virus	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Treponema pallidum (Syphilis)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Trichimonas	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Human Papillomavirus (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Infectious Diseases					
HIV/AIDS	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Rubella seronegativity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Influenza	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Varicella	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Group B strep	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Substance Abuse					
Toxicology Screen	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Alcohol	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Nicotine/tobacco	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Crack	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Cocaine	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Crystal meth	☐ Yes	☐ Yes	☐ Yes	☐ Yes	

(methamphetamine)					
Heroin	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Opiates	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Marijuana or hashish	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
PCP, angel dust, LSD	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Speed/uppers	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Methadone	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Drug use but unknown type	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other: specify in comments	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Were any of the above substances injected? ☐ No ☐ Yes (specify in comments) ☐ Unknown					
Other Risk Factors					
Obesity	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Isotretinoins	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Oral anticoagulant	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Anti-epileptic drugs	☐ Yes	☐ Yes	☐ Yes	☐ Yes	
Other maternal health condition (specify in comments)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	

Hospitalization and Emergency Room Visits

23) List the hospital visits or emergency department visits.

☐ There were no hospital or emergency visits (*skip to #24*).

Visit	Date of Admission	Date of discharge	Type of hospital visit	Admission diagnosis	Discharge Diagnoses	HIV status was documented?	Treatment
1	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
2	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
3	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	

23a) Is there documentation that the woman was subsequently referred to another provider?

☐ Yes *(specify for what diagnosis and to whom)*_________________________________

____

☐ No

23b) List Significant Outcomes of hospitalizations and/or ER visits:

____

____

____

____

Additional comments: Please note any additional/clarifying comments related to the woman's hospitalization and emergency room visits.

____

____

Overall Health Education

24) At any time were any of the following topics documented as having been discussed?

☐ There were none documented

Topic	Discussed	Comments
Transmitting HIV or STDs	☐ Yes	
Medicines to help protect the baby from getting syphilis	☐ Yes	
Importance of syphilis medicines	☐ Yes	
Syphilis medicines the baby should receive	☐ Yes	
Medication adherence	☐ Yes	
Pregnancy Interval	☐ Yes	
Finding a doctor or nurse practitioner to care for the baby	☐ Yes	
How smoking could affect the baby	☐ Yes	
Depression	☐ Yes	
How long to wait before having another baby (child spacing)	☐ Yes	
Domestic Violence	☐ Yes	
Breast care	☐ Yes	
Safe sleep/SIDS risk reduction activities	☐ Yes	
Safe infant feeding	☐ Yes	
Partner counseling and referral services	☐ Yes	
Other Topics Documented (specify) ____	☐ Yes	

Additional comments: Please note any additional/clarifying comments related to health education the woman received.

____

____

Stressors, Violence, Mental Health, Social Support & Case Management

25) Was there documentation that a social worker or case manager saw the mother?

____

☐ Yes
☐ No
☐ Unknown/Undocumented

26) Did medical, nursing or social work personnel identify any of the problems listed below? (check all that apply) Indicate whether a case management plan was developed for identified problems.

☐ Chart does not indicate a problem (*skip to 27*).

Problem	Documented <u>during</u> 6-week postpartum period	Documented <u>after</u> 6-week postpartum period	Case management plan developed or in place?	Was this a Ryan White case management resource?
Disturbed relationship with other child/children	☐	☐	☐	☐ Yes
Depression	☐	☐	☐	☐ Yes
Inadequate support systems	☐	☐	☐	☐ Yes
Housing inadequate/homeless	☐	☐	☐	☐ Yes
Need for Public Assistance, Medicaid, Food Stamps, WIC, or other financial support	☐	☐	☐	☐ Yes
Physical assault by any partner	☐	☐	☐	☐ Yes
Threats, restriction of movement or contacting other people by any partner	☐	☐	☐	☐ Yes
Forced sex	☐	☐	☐	☐ Yes
Substance abuse	☐	☐	☐	☐ Yes
Mother abused as child	☐	☐	☐	☐ Yes
Drug/EtOH abuse (mother/partner)	☐	☐	☐	☐ Yes
Employment/education needs (mother/partner)	☐	☐	☐	☐ Yes
Crime/legal problems (mother/partner)	☐	☐	☐	☐ Yes
Lack of transportation	☐	☐	☐	☐ Yes
Other *(specify)*:______________________	☐	☐	☐	☐ Yes

26a) What ***treatments*** were documented for these problems?
1 ____
2 ____
3 ____
4 ____
5 ____
☐ None
☐ Unknown/Not documented

27) Is there documentation of referral(s) for any support services during the postpartum care? (Check all that apply)

☐ No referrals for support services were documented in the post pregnancy period

<u>**Referral Type**</u>	
☐ Financial Planning	

☐ WIC	
☐ Food Stamps	
☐ Housing Authority	
☐ Group Shelter	
☐ Smoking Cessation Program	
☐ Methadone Maintenance Program	
☐ Other Drug Treatment Program	
☐ Medicaid	
☐ Unemployment Office	
☐ Child Protective Services	
	Was this a Ryan White resource?
☐ PHN Home Assessment/Follow-up	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Homemaker/Home health aide	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Mental Health Services	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Clinical Case Management (e.g. Healthy Start)	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Ongoing Social Work Case Management	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Family Planning	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Other (*specify*):	☐ Yes ☐ No ☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to stressors, violence, mental health, social support and case management.

____

____

Additional Comments

Use this space to record any other information that might be of interest for this review.

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This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the American College of Obstetricians and Gynecologists (the College), City**M**at**CH**, and the National Fetal and Infant Mortality Review Program (NFIMR).

Pediatric Outpatient and Hospitalization Records from 0–12 Months

Case Number: ______________________ Abstractor's name: ____________________________

Abstraction Completion Date: ___/___/___

1) This form collects information relating to the medical care the infant received. Please indicate the sources used to complete this form (check all that apply):
   ☐ Pediatric Outpatient Care record
   ☐ HIV Care Record
   ☐ Pediatric Hospitalization Record
   ☐ Other (*specify*): ______________________
   ☐ Other (*specify*): ______________________

Introductory Information

2) Did the infant receive care through six months of age?
☐ Yes
☐ No
☐ Not documented

3) What was the payor source for care? *(check all that apply)*

	Pediatric Care	HIV Care (if applicable)
Private Insurance	☐	☐
Traditional Medicaid	☐	☐
Medicaid Managed Care Organization (MCO) or Health Maintenance Organization (HMO)	☐	☐
Managed Care Organization (MCO) or Health Maintenance Organization (HMO), private payor	☐	☐
Medicaid, type unknown	☐	☐
Medicare	☐	☐
TriCare/Military insurance	☐	☐
Self pay	☐	☐
Self pay but eligible for Medicaid	☐	☐
Other *(specify)*:		

4) For each type of care, indicate where the services were received and the provider type. (*check all that apply)*

	Pediatric Care	HIV Care (if applicable)	Pre-existing Dx Follow-Up	Other care (specify)
Care not received	☐	☐	☐	
Facility Type				
Private Practice	☐	☐	☐	
Internal Medicine/Family Practice Private Practice	☐	☐	☐	
Pediatric HIV specialty clinic	☐	☐	☐	
County/Local Health Department	☐	☐	☐	
Managed Care Organization (MCO) or Health Maintenance Organization (HMO)	☐	☐	☐	
Community Health Center	☐	☐	☐	
Correctional facility	☐	☐	☐	
Clinic in a hospital	☐	☐	☐	
Unknown/Not Documented	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	
Other (specify): ___________	☐	☐	☐	
Provider Type				
General pediatric care provider (pediatrician, , pediatric nurse practitioner, pediatric physician assistant)	☐	☐	☐	☐
Family medicine care provider (family physician, family nurse practitioner, family physician assistant)	☐	☐	☐	☐
ID specialist provider (ID physician, ID nurse practitioner, ID physician assistant)	☐	☐	☐	☐
Other (specify): ___________	☐	☐	☐	☐

4a) Was the pediatric care provider also an ID specialist?

☐ Yes

☐ No

5) Date of birth (*used to calculate age at events, not stored in the data system)*

Month Day Year

6) Infant's race/ethnicity?

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (select one or more)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

7) Who is the infant's primary care giver?
- ☐ Birth Parents
  - ☐ Mother and Father
  - ☐ Mother Only
  - ☐ Father Only
- ☐ Foster Parents
  - ☐ Mother and Father
  - ☐ Mother Only
  - ☐ Father Only
- ☐ Adoptive Parents
  - ☐ Mother and Father
  - ☐ Mother Only
  - ☐ Father Only
- ☐ Other *(specify)*:____
- ☐ Unknown/Not documented

8) What were the infant feeding practices? (*Check all that apply*)
- ☐ Exclusive Breastfeeding (specify the duration of breastfeeding: _______weeks or ______months)
- ☐ Mixed feeding (breast milk and formula or solid)
- ☐ Formula
- ☐ Unknown/Not documented

Additional comments: Please note any other comments about the introductory information.

____

____

____

Syphilis Testing, Diagnosis and Care

9) Was the mother's syphilis status noted in the pediatric record?

☐ Yes
☐ No
☐ Unknown/Not documented

9a) Did mother <u>ever</u> have a reactive treponemal test result (e.g., EIA, TP-PA)?

☐ Yes
☐ No
☐ Unknown/Not documented

9b) Did mother have a reactive non-treponemal test result (e.g., RPR, VDRL) <u>while pregnant with the infant</u>?

☐ Yes (please provide date, if available: _____/_____/__________)
☐ No
☐ Unknown/Not documented

9c) If mother had a reactive treponemal or non-treponemal test result while pregnant with the infant, did she receive treatment with benzathine penicillin 30 or more days before delivery?

☐ Mother not treponemal or non-treponemal test reactive
☐ Yes
☐ No
☐ Unknown/Not documented

10) Was the infant treated with penicillin during the first year of life?

☐ Yes
☐ No *(skip to #10b)*
☐ Unknown *(skip to #10b)*

10a) Please list when penicillin was given to the infant during the first year of life, including dose.

Drug Name	Date Given	Dosage
I.	_______/_______/____________	
II.	_______/_______/____________	
III.	_______/_______/____________	
IV.	_______/_______/____________	
V.	_______/_______/____________	
VI.	_______/_______/____________	

VII.	______/______/__________	
VIII.	______/______/__________	

10b) If penicillin was not prescribed during the first year of life indicate reason *(check all that apply)*:

☐ No maternal syphilis test documented in pregnancy
☐ Documented non-reactive treponemal and/or non-treponemal maternal test result during pregnancy
☐ Mother was allergic to penicillin
☐ Penicillin was refused for reasons other than allergy
☐ Mother was not receiving prenatal care
☐ Other *(specify)*:____
☐ Unknown/Not documented

11) Documented syphilis testing of the infant:

☐ No testing done

11a) darkfield microscopy and serologic testing

Date testing offered	Darkfield microscopy result, if applicable	Treponemal (e.g., EIA, TP-PA) test result, if applicable	Nontreponemal (e.g., RPR, VDRL) titer, if applicable	Date patient informed of result

11b) other testing

Date testing offered	Cerebrospinal fluid (CSF) VDRL, if applicable	CSF white blood cell (WBC) count, if applicable	CSF protein, if applicable	Long bone X-ray, if applicable	Date patient informed of result

12) Documented physical findings of the infant (check all that apply):

- ☐ No signs or symptoms noted
- ☐ Hepatosplenomegaly
- ☐ Jaundice/hepatitis
- ☐ Pseudoparalysis
- ☐ Edema
- ☐ Condyloma lata
- ☐ Hemorrhagic nasal discharge ("snuffles")
- ☐ Syphilitic skin rash
- ☐ Other (specify) ____
- ☐ No physical exam noted

13) When was the infant diagnosed with congenital syphilis?
☐ Date: ___________ (mo/da/yr)
☐ Unknown/Not Documented

14) When was the infant's caregiver notified of the infant's status?
☐ Date: ___________(mo/da/yr)
☐ Unknown/Not Documented

ER Visits and Hospitalizations

15) Were pediatric hospitalization records reviewed?
☐ Yes
☐ No, record not available *(skip to Infant Care section)*
☐ No, all care received out of the jurisdiction *(skip to Infant Care section)*
☐ No, infant was not seen at a hospital from 0–12 months *(skip to Infant Care Section)*
☐ No *(specify)*____*(skip to Infant Care section)*

16) List hospital visits or emergency department visits.
☐ No documented hospital or ER visits.

Visit	Date of Admission	Date of discharge	Type of hospital visit	Admission Diagnosis	Discharge Diagnoses	History of congenital syphilis was documented?	Treatment
1	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
2	/ /	/ /	☐ ED Only ☐ Hospital Admission			☐ Yes	
3	/ /	/ /	☐ ED Only ☐ Hospital			☐ Yes	

			Admission				

16a) Is there documentation that the infant was subsequently referred to another provider?

☐ Yes *(specify for what diagnosis and to whom)*____

____

☐ No

16b) List significant outcomes of hospitalizations and/or ER visits:

____

____

____

Additional comments: Please note any additional/clarifying comments related to hospitalizations.

____

____

Infant Care

17) Complete the following table for all well-baby outpatient visits (other than congenital syphilis-specific care) in chronological order starting with the first visit closest to date of birth.

☐ Information on well-baby outpatient visits unknown/not available.

Visit #	**Infant age (weeks)**	**Missed appointment?**	**Growth NOT Within Normal Limits (mark all that apply)**	**Vaccines Given?**	**Dev. Assess?**
1	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
2	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
3	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
4	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
5	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
6	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No

7	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No
8	____ weeks	☐ Yes ☐ No	☐Ht. ☐ Wt. ☐ HC	☐ Yes ☐ No	☐ Yes ☐ No

18) Complete the following table for all sick baby outpatient visits (other than congenital syphilis-specific care) in chronological order starting with the first visit closest to date of birth.

☐ No sick baby visits documented.

Visit Date mm/dd/yyyy	Site	Diagnoses	Comments
_____/_____/_____	☐ Private physician ☐Clinic ☐ER ☐Other (specify): ________________		
_____/_____/_____	☐ Private physician ☐Clinic ☐ER ☐Other (specify): ________________		
_____/_____/_____	☐ Private physician ☐Clinic ☐ER ☐Other (specify): ________________		
_____/_____/_____	☐ Private physician ☐Clinic ☐ER ☐Other (specify): ________________		

Additional comments: Please note any additional/clarifying comments related to infant care.

____

____

Case management services received

19) Was there documentation that a social worker or case manager contacted this family during any of the following time periods? *(check all that apply)*

☐ Yes, at the time of delivery

☐ Yes, during ambulatory infant care

☐ Yes, during an emergency room visit that did not result in admission
☐ Yes, during infant hospitalization subsequent to discharge after delivery
☐ No, social worker/case manager did not contact this family

20) Did medical, nursing or social work personnel identify any of the problems listed below? Indicate whether a case management plan was developed for identified problems. (check all that apply)

☐ Record does not indicate a problem.

Problem	Identified?	Was a case management plan developed?	Was this a Ryan White case management resource?
Disturbed relationship with other child/children	☐	☐	☐ Yes
Depression	☐	☐	☐ Yes
Inadequate support systems	☐	☐	☐ Yes
Housing inadequate/homeless	☐	☐	☐ Yes
Communication difficulties (no phone)	☐	☐	☐ Yes
History of abuse (other children)	☐	☐	☐ Yes
Need for Public Assistance, Medicaid, Food Stamps, WIC, or other financial support	☐	☐	☐ Yes
Physical assault by any partner	☐	☐	☐ Yes
Threats/restriction of movement or from contacting other people by any partner	☐	☐	☐ Yes
Physical/developmental handicap (mother/partner)	☐	☐	☐ Yes
Forced sex	☐	☐	☐ Yes
Substance abuse	☐	☐	☐ Yes
Mother abused as child	☐	☐	☐ Yes
Drug/EtOH abuse (mother/partner)	☐	☐	☐ Yes
Employment/education needs (mother/partner)	☐	☐	☐ Yes
Crime/legal problems (mother/partner)	☐	☐	☐ Yes
Lack of transportation	☐	☐	☐ Yes
Teen mother	☐		
Single mother	☐		
Chronic illness of the mother or infant requiring continuing medical care (physical or mental) *(specify)*:________________	☐	☐	☐ Yes
Other *(specify)*:________________	☐	☐	☐ Yes

20a) What **treatments *or other follow up*** was documented for these problems?

1 ________________
2 ________________
3 ________________
4 ________________
5 ________________

☐ None
☐ Unknown/Not documented

21) Is there documentation of referral(s) for any support services at any of the visits? (Check all that apply)

☐ No referrals for support services were documented

Referral Type	
☐ Financial Planning	
☐ WIC	
☐ Food Stamps	
☐ Housing Authority	
☐ Group Shelter	
☐ Smoking Cessation Program	
☐ Alcohol Treatment Program	
☐ Methadone Maintenance Program	
☐ Other Drug Treatment Program	
☐ Genetic evaluation/counseling	
☐ Medicaid	
☐ Unemployment Office	
☐ Child Protective Services	
☐ GED programs	
☐ Legal aid	
☐ Physically handicapped child program	
☐ Infant/child health program	
☐ Home technology (ie photo therapy, etc.)	Specify:___________________________
	Was this a Ryan White resource?
☐ PHN Home Assessment/Follow-up	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Homemaker/Home health aide	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Mental Health Services	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Clinical Case Management (e.g. Healthy Start)	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Ongoing Social Work Case Management	☐ Yes ☐ No ☐ Unknown/Not documented
☐ Family Planning	☐ Yes ☐ No ☐ Unknown/Not documented

☐ Other (*specify*):	☐ Yes ☐ No ☐ Unknown/Not documented

Additional comments: Please note any additional/clarifying comments related to case management services.

____

____

____

Health Education

22) Did the person who brought the infant for care receive health education on any of the following? (check all that apply)

☐ No discussions related to health education were documented.

Topic	Discussed?
Transmitting HIV or STDs	☐ Yes
Medicines to help protect the baby from getting syphilis	☐ Yes
Importance of mom/infant getting treatment for syphilis	☐ Yes
Pregnancy Interval	☐ Yes
Finding a doctor or nurse practitioner to care for the baby	☐ Yes
How smoking could affect the baby	☐ Yes
Depression	☐ Yes
Domestic Violence	☐ Yes
Breast care	☐ Yes
Safe sleep/SIDS risk reduction activities	☐ Yes
Safe infant feeding	☐ Yes
Bath Safety	☐ Yes
Small object avoidance	☐ Yes
Protection from falls	☐ Yes
Use of infant car seat	☐ Yes
Shaken Baby Syndrome	☐ Yes
Use of home smoke detector	☐ Yes
Other Topics Documented (specify) ____	☐ Yes

Additional comments: Please note any additional/clarifying comments related to health education.

Additional Comments

Use this space to record any other information that might be of interest for this review.

This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the Division of STD Prevention at CDC, the American College of Obstetricians and Gynecologists (the College), City**M**at**CH**, and the National Fetal and Infant Mortality Review Program (NFIMR).