

**National HIV Surveillance System (NHSS)**

Attachment 3d.

Perinatal HIV Exposure Reporting (PHER)

Infant's State Number \_\_\_\_\_  
 Infant's City Number \_\_\_\_\_

Mother's State Number \_\_\_\_\_  
 Mother's City Number \_\_\_\_\_

Form Approved OMB No. NNNN-NNNN Exp. Date MM/DD/YYYY

**1. If information on the mother is not available, was the child adopted, or in foster care?**

Yes  No  Not applicable

**2. Records abstracted**

(1 = Abstracted, 2 = Attempted—record not available, 3 = Not abstracted, 4 = Attempted—will try again)

____ Prenatal care records	____ Pediatric medical records (non-HIV clinic or provider)
____ Maternal HIV clinic records	____ Birth certificate
____ Labor and delivery records	____ Death certificate
____ Pediatric birth records	____ Health department records
____ Pediatric HIV medical records	____ Other (Specify) _____

**3. Weeks' gestation at first prenatal care visit**

\_\_\_ weeks

**4. Was the mother screened for any of the following during pregnancy?**

(Check test(s) performed before birth, but closest to date of delivery or admission to labor and delivery)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Group B strep	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (HBsAg)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Diagnosis (for the mother) of the following conditions during this pregnancy or at the time of labor and delivery**

(See instructions for data abstraction for definitions)

	Yes	Date (mm/dd/yyyy)	No	Not documented	Record not available	Unknown
Bacterial vaginosis	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Chlamydia trachomatis</i> infection	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital herpes	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group B strep	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (HbsAg+)	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PID	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trichomoniasis	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. Mother's reproductive history**

\_\_\_\_\_ No. of previous pregnancies      \_\_\_\_\_ No. of previous miscarriages or stillbirths  
 \_\_\_\_\_ No. of previous live births      \_\_\_\_\_ No. of previous induced abortions OR \_\_\_\_\_ Total No. of previous abortions

**7. Complete the chart for all siblings.**

	Date of birth (mm/dd/yyyy)	Age (yrs: mos as of mm/yyyy)	HIV serostatus (See list below)	State Number	City Number
Sib 1	___/___/___	___:___ as of ___/___/___	_____	_____	_____
Sib 2	___/___/___	___:___ as of ___/___/___	_____	_____	_____
Sib 3	___/___/___	___:___ as of ___/___/___	_____	_____	_____
Sib 4	___/___/___	___:___ as of ___/___/___	_____	_____	_____

HIV serostatus: 1 = Infected, 2 = Not infected, 3 = Indeterminate, 9 = Not documented, U = Unknown

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0573). **Do not send completed form to this address.**

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

**8. Was substance use during pregnancy noted in the medical or social work records?**

Yes  No (Go to 9)  Record not available (Go to 9)  Unknown

**8a. If yes, indicate which substances were used during pregnancy. (Check all that apply)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alcohol         | <input type="checkbox"/> Cocaine       | <input type="checkbox"/> Marijuana (cannabis, THC, cannabinoids) | <input type="checkbox"/> Opiates                         |
| <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> Crack cocaine | <input type="checkbox"/> Methadone                               | <input type="checkbox"/> Other (Specify) _____           |
| <input type="checkbox"/> Barbiturates    | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methamphetamines                        | <input type="checkbox"/> Specific drug(s) not documented |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Heroin        | <input type="checkbox"/> Nicotine (any tobacco product)          |  |

**8b. If substances used, were any injected?**

Yes  No  Not documented  Unknown  Specify injected substance(s). \_\_\_\_\_

**9. Was a toxicology screen done on the mother (either during pregnancy or at the time of delivery)?**

Yes, positive result (Check all that apply)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alcohol         | <input type="checkbox"/> Cocaine       | <input type="checkbox"/> Marijuana (cannabis, THC, cannabinoids) | <input type="checkbox"/> Opiates                         |
| <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> Crack cocaine | <input type="checkbox"/> Methadone                               | <input type="checkbox"/> Other (Specify) _____           |
| <input type="checkbox"/> Barbiturates    | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methamphetamines                        | <input type="checkbox"/> Specific drug(s) not documented |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Heroin        | <input type="checkbox"/> Nicotine (any tobacco product)          |  |

Yes, negative result

No

Toxicology screen not documented

**10. Was a toxicology screen done on the infant at birth?**

Yes, positive result (Check all that apply)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alcohol         | <input type="checkbox"/> Cocaine       | <input type="checkbox"/> Marijuana (cannabis, THC, cannabinoids) | <input type="checkbox"/> Opiates                         |
| <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> Crack cocaine | <input type="checkbox"/> Methadone                               | <input type="checkbox"/> Other (Specify) _____           |
| <input type="checkbox"/> Barbiturates    | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methamphetamines                        | <input type="checkbox"/> Specific drug(s) not documented |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Heroin        | <input type="checkbox"/> Nicotine (any tobacco product)          |  |

Yes, negative result

No

Toxicology screen not documented

**11. Was the mother's HIV serostatus noted in her prenatal care medical records?**

Yes, HIV-positive  Yes, HIV-negative  No  No prenatal care  Record not available  Unknown

**12. Were antiretroviral drugs prescribed for the mother during this pregnancy?**

Yes (Complete table)  No (Go to 12a)  Not documented (Go to 13)  Record not available (Go to 13)  Unknown (Go to 13)

	Drug name	Drug refused	Date drug started (mm/dd/yyyy)	Gestational age drug started (weeks; round down)	Drug stopped			Date stopped (if yes in preceding column) (mm/dd/yyyy)	Stop codes (See list on p. 4)
					Yes	No	ND		
i.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
ii.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iii.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iv.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
v.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
vi.	_____	<input type="checkbox"/>	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

(After completing table, go to 13)

**12a. If no antiretroviral drug was prescribed during pregnancy, check reason.**

- |   |   |  |                                  |
|---|---|--|----------------------------------|
| <input type="checkbox"/> No prenatal care                 | <input type="checkbox"/> Mother known to be HIV-negative during pregnancy | <input type="checkbox"/> Not documented        | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> HIV serostatus of mother unknown | <input type="checkbox"/> Mother refused                                   | <input type="checkbox"/> Other (Specify) _____ |                                  |

**13. Was mother's HIV serostatus noted in her labor and delivery records?**

Yes, HIV-positive  Yes, HIV-negative  No  Record not available  Unknown

**14. Did mother receive antiretroviral drugs during labor and delivery?**

- Yes (Complete table)     No (Go to 14a)     Not documented (Go to 15)     Record not available (Go to 15)     Unknown (Go to 15)

	Drug name	Drug refused	Date received (mm/dd/yyyy)	Time received (See military time)	Type of administration		
					Oral	IV	Not documented
i.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(After completing the table, go to 15)

Military time: noon = 12:00; midnight = 00:00

**14a. If no antiretroviral drug was received during labor and delivery, check reason.**

- Precipitous delivery/STAT Cesarean delivery     HIV serostatus of mother unknown     Mother tested HIV-negative during pregnancy     Other (Specify) \_\_\_\_\_
- Prescribed but not administered     Birth not in hospital     Mother refused     Not documented     Unknown

**15. Was mother referred for HIV care after delivery?**

- Yes     No (Go to 17)     Not documented (Go to 17)     Record not available (Go to 17)     Unknown

**16. If yes, indicate mother's first CD4 result or first viral load result after discharge from hospital (up to 6 months after discharge).**

16a. CD4 result			16b. Viral load result		
	<input type="checkbox"/> Not done	<input type="checkbox"/> Not available		<input type="checkbox"/> Not done	<input type="checkbox"/> Not available
Result	Unit	Date blood drawn (mm/dd/yyyy)	Result in copies/mL	Result in logs	Date blood drawn (mm/dd/yyyy)
_____	cells/ $\mu$ L	___/___/___	_____	_____	___/___/___
___	%	___/___/___			

**17. Birth information**

- Birth not in hospital     Record not available

	Time (See military time)	Date (mm/dd/yyyy)		Time (See military time)	Date (mm/dd/yyyy)
Onset of labor	___:___	___/___/___	Rupture of membranes	___:___	___/___/___
Admission to labor and delivery	___:___	___/___/___	Delivery	___:___	___/___/___

Military time: noon = 12:00; midnight = 00:00

**18. If Cesarean delivery, mark all the following indications that apply.**

- HIV indication (high viral load)     Mother's or physician's preference     Other (e.g., herpes, disproportion) (Specify) \_\_\_\_\_
- Previous Cesarean (repeat)     Fetal distress
- Malpresentation (breech, transverse)     Placenta abruptia or p. previa     Not specified
- Prolonged labor or failure to progress     Not applicable

**19. Was mother's HIV serostatus noted on the child's birth record?**

- No     Yes, HIV-positive     Yes, HIV-negative     Record not available     Unknown

**20. Were antiretroviral drugs prescribed for the child?**

Yes (**Complete table**)     No (**Go to 20a**)     Not documented     Record not available     Unknown

	Drug name	Drug refused	Date drug started (mm/dd/yyyy)	Time started (See military time)	Drug stopped				Stop date (if therapy not completed) (mm/dd/yyyy)	Stop codes (See list)
					Yes	No	ND	UNK		
i.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
ii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iii.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
iv.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
v.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
vi.	_____	<input type="checkbox"/>	___/___/___	___:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

Military time: noon = 12:00; midnight = 00:00

**20a. If no antiretroviral drug was prescribed, indicate reason.**

- HIV serostatus of mother unknown
- Mother known to be HIV-negative during pregnancy
- Mother refused
- Other (Specify) \_\_\_\_\_
- Not documented

**Stop codes** (2 codes allowed; if more, choose the 2 most important)

- |   |  |
|---|--|
| <b>S1</b> = Adverse events (toxicity, lack of tolerance)            | <b>S9</b> = Pregnancy                                |
| <b>S2</b> = ART completed   | <b>S10</b> = Child determined not to be HIV infected |
| <b>S3</b> = Drug resistance detected                                | <b>S11</b> = Improving effectiveness                 |
| <b>S4</b> = Poor adherence  | <b>S12</b> = Improving convenience                   |
| <b>S5</b> = Inadequate effectiveness                                | <b>S13</b> = Reason not indicated; unknown           |
| <b>S6</b> = Strategic treatment interruption (planned drug holiday) | <b>S14</b> = Mother couldn't afford drugs            |
| <b>S7</b> = Drug interactions                                       | <b>Sxx</b> = Other reason                            |
| <b>S8</b> = Mother's choice   |  |

**List of abbreviations**

ART	antiretroviral therapy
ND	not documented
PCP	<i>Pneumocystis jirovecii</i> pneumonia [ <i>jirovecii</i> is now preferred to <i>carinii</i> ; abbreviation is the same]
PID	pelvic inflammatory disease
STAT	immediately ( <i>statim</i> )

**Comments**

Please include comments or clinical information you consider relevant to the overall understanding of this child's HIV exposure or infection status. State the date and source of the information.