Perinatal HIV Report

Minnesota law, specifically Minnesota Rules Chapter 4605.7044, requires the reporting of pregnancy in a person chronically infected with HIV, including AIDS, to the Minnesota Department of Health **within one working day of knowledge of the pregnancy**. This form must be filled in, printed, and faxed to the number listed at the bottom of the form.

Complete this form twice per patient, per pregnancy:

1. When the clinician is made aware of the pregnancy (or if pregnant already, upon HIV diagnosis);
2. At the time of pregnancy outcome (birth, spontaneous abortion, or induced abortion)

Please select all that apply:

☐ OB care established? OB clinic: _____ Clinician: _____ Phone number: _____

☐ Infectious Disease (ID) care established? ID clinic: _____ Clinician: _____

Phone number: _____

☐ Plan in place to review delivery plan with the L & D unit of the hospital at approximately 36 weeks gestation.

Have you sent a referral for care coordination/request consultation with **MN Perinatal & Pediatric HIV Program, Children's Hospital and Clinics of Minnesota**? To place a referral or request a consulation, contact RN Nurse Coordinator 612-387-2989.

Person completing form: _____

Facility: _____ Phone number: _____

Patient's clinican (if not identified above): _____ Date faxed: ___/___/_____

Fax number of person completing this form: _____

Patient Information

First name: _____ Middle initial: _____ Last name: _____

Date of birth: ___/___/_____

Current HIV medication: _____ Date began: ___/___/_____

Currently pregnant?

☐ Yes If yes, expected date of delivery: ___/___/_____ Expected location of delivery: _____

☐ No If no, pregnancy outcome: ☐ Live birth ☐ Spontaneous or induced abortion ☐ Still birth

Date of outcome: ___/___/_____

Infant Information

First name: _____ Middle initial: _____ Last name: _____

Date of birth: ___/___/_____ Sex at birth: ☐ Male ☐ Female

Pediatric clinic and/or provider: _____

Breast/Chestfeeding: ☐ Yes ☐ No ☐ Maybe

Comments:

Please fax completed form to: 800-318-8137, Minnesota Dept of Health, ATTN: Surveillance

DEPARTMENT OF HEALTH
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