

Pediatric HIV Exposure Reporting (PHER)

Form Approved OMB No. 0920-0573 Exp. Date 02/29/2016

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 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.)	State No.	City No.
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 18 to 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 10.) 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

Drug name (See list on p. 8.)	Other (specify)	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. 8.)
					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.

- No prenatal care Mother known to be HIV-negative during pregnancy Not documented Unknown
 HIV serostatus of mother unknown Mother refused 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

Drug name (See list.)	Other (specify)	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 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.

- | | | | |
|----------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Precipitous delivery/STAT Cesarean delivery | <input type="checkbox"/> HIV serostatus of mother unknown | <input type="checkbox"/> Mother tested HIV-negative during pregnancy | <input type="checkbox"/> Other (Specify.) _____ |
| <input type="checkbox"/> Prescribed but not administered | <input type="checkbox"/> Birth not in hospital | <input type="checkbox"/> Mother refused | <input type="checkbox"/> Not documented |
| | | | <input type="checkbox"/> Unknown |

15. Was mother referred for HIV care after delivery?

- Yes No (Go to 18.) Not documented (Go to 17.) Record not available (Go to 17.) Unknown

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

16a. CD4 result

- Not done Not available

Result	Unit	Date blood drawn (mm/dd/yyyy)
_____	cells/ μ L	____/____/____
_____	%	____/____/____

16b. Viral load

- Not done Not available

Result in copies/mL	Result in logs	Date blood drawn (mm/dd/yyyy)
_____	_____	____/____/____

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.

- | | | |
|-----------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> HIV indication (high viral load) | <input type="checkbox"/> Mother's or physician's preference | <input type="checkbox"/> Other (e.g., herpes, disproportion) (Specify) _____ |
| <input type="checkbox"/> Previous Cesarean (repeat) | <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Not specified <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Malpresentation (breech, transverse) | <input type="checkbox"/> Placenta abruptia or p. previa | |
| <input type="checkbox"/> Prolonged labor or failure to progress | | |

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 during the first 6 weeks of life?

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

Drug name (See list.)	Other (specify)	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 on p. 8.)
					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 during the first 6 weeks of life, indicate reason.

- | | |
|---------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> HIV serostatus of mother unknown | <input type="checkbox"/> Other (Specify.) _____ |
| <input type="checkbox"/> Mother known to be HIV-negative during pregnancy | <input type="checkbox"/> Not documented |
| <input type="checkbox"/> Mother refused | |

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.

Antiretroviral drugs

NNRTI

Delavirdine (Rescriptor)
Efavirenz (Sustiva)
Nevirapine (Viramune, NVP)

NRTI

Abacavir (Ziagen, ABC)
Combivir (AZT & 3TC)
Didanosine (ddI, Videx)
Emtriva (Emtricitabine or FTC)
Epzicom (Abacavir/3TC, Kivexa)
Lamivudine (3TC, Epivir)
Stavudine (d4T, Zerit)
Trizivir (AZT & 3TC & Abacavir)
Truvada (Tenofovir DF/Emtricitabine)
Videx® EC (Didanosine)
Viread (Tenofovir)
Zalcitabine (ddC, Hivid)
Zidovudine (AZT, Retrovir)

Protease inhibitor

Amprenavir (Agenerase)
Darunavir (Prezista)
Indinavir (Crixivan)
Kaletra (Lopinavir, Ritonavir)
Lexiva (Fosamprenavir)
Nelfinavir (Viracept)
Reyataz (Atazanavir or ATV)
Ritonavir (Norvir)
Saquinavir (Fortavase, Invirase)
Tipranavir (Aptivus)

Protease inhibitor

Amprenavir (Agenerase)
Darunavir (Prezista)
Indinavir (Crixivan)
Kaletra (Lopinavir, Ritonavir)
Lexiva (Fosamprenavir)
Nelfinavir (Viracept)
Reyataz (Atazanavir or ATV)
Ritonavir (Norvir)
Saquinavir (Fortavase, Invirase)
Tipranavir (Aptivus)

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

S1 = Adverse events (toxicity, lack of tolerance)

S2 = ART completed

S3 = Drug resistance detected

S4 = Poor adherence

S5 = Inadequate effectiveness

S6 = Strategic treatment interruption (planned drug holiday)

S7 = Drug interactions

S8 = Mother's choice

S9 = Pregnancy

S10 = Child determined not to be HIV infected

S11 = Improving effectiveness

S12 = Improving convenience

S13 = Reason not indicated; unknown

S14 = Mother couldn't afford drugs

Sxx = Other reason

List of abbreviations

ACTG	AIDS Clinical Trials Group
ART	antiretroviral therapy
EIA	enzyme immunoassay
HARS	HIV/AIDS Reporting System
HMO	health maintenance organization
ICD-9	International Classification of Diseases, Ninth Revision
ICD -10	International Classification of Diseases, Tenth Revision
IFA	immunofluorescent assay
ND	not documented
NNRTI	nonnucleoside reverse transcriptase inhibitor
NRTI	nucleoside reverse transcriptase inhibitor
NRR	no risk factor reported
OB-GYN	obstetric-gynecologic or obstetrician-gynecologist
PCP	<i>Pneumocystis jirovecii</i> pneumonia [<i>jirovecii</i> is now preferred to <i>carinii</i> ; abbreviation is the same]
PI	protease inhibitor
PID	pelvic inflammatory disease
STAT	immediately (<i>statim</i>)
WB	Western blot