John Bel Edwards
GOVERNOR

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State of Louisiana

Louisiana Department of Health
Office of Public Health

HIV/SYPHILIS DURING PREGNANCY REPORTING FORM

The Louisiana Public Health Sanitary Code mandates the reporting of pregnancy status for women diagnosed with HIV and/or syphilis, which allows Louisiana programs to target high-risk pregnancies for follow-up.

REPORT DATE:__________________ **REPORTING FACILITY**: ________________________________

Patient Information

Full Name	First	Last	Maiden
Address	Street Address		Apartment/Unit #
	City and Zip code		Phone Number
Emergency Contact Name and Phone No.		**DOB (mm/dd/yyyy)**	__ __ / __ __ /__ __ __ __
Date of Pregnancy Diagnosis (mm/dd/yyyy)			__ __ / __ __ /__ __ __ __
Estimated Delivery Date (mm/dd/yyyy)			__ __ / __ __ / __ __ __ __

Linkage to Care

The patient is currently diagnosed with:		☐ HIV ☐ Syphilis ☐ Both ☐ Other___________________________	
Is the patient engaged in OB and/or prenatal care?	☐ Y ☐ N ☐ UNK	**If the patient is currently infected with syphilis, what is the clinical stage of diagnosis?**	☐ Primary ☐ Secondary ☐ Early Latent ☐ Late Latent
Is the patient currently on antiretroviral therapy (ARVs) for HIV?	☐ Y ☐ N ☐ UNK ☐ N/A	**Has the patient been treated for the most recent infection of syphilis?**	☐ Y ☐ N ☐ UNK ☐ N/A
Is the patient currently engaged in HIV Care?	☐ Y ☐ N ☐ UNK ☐ N/A	**If the patient was treated for a current syphilis infection, please record treatment and dosage:**	☐ 2.4 MU benzathine penicillin ☐ 4.8 MU benzathine penicillin ☐ 7.2 MU benzathine penicillin ☐ Other ____________ ☐ N/A
		Date of Syphilis Treatment:	__ __/__ __/__ __ __ __
Are you concerned about any of the following with your patient? Check all that apply.		☐ Housing ☐ Transportation ☐ Nutrition/Food Assistance ☐ Med Adherence ☐ Substance Abuse ☐ Mental Health ☐ None ☐ Other (please specify): ____	

Provider Information

Patient's Provider/Person Completing Form	
Phone Number	

Report diagnosis of HIV/syphilis during pregnancy within one business day.

Completed forms should be sent to the Perinatal STD/HIV Surveillance Supervisor
at the Office of Public Health STD/HIV Program.

Report by Phone: (504) 568-3384
Confidential Fax: (504) 568-8384
Mail (completed forms must be mailed in a sealed enveloped marked "Confidential"):
1450 Poydras Street, Suite 2136, New Orleans, LA 70112

Instructions for the HIV/Syphilis During Pregnancy Reporting Form

Louisiana Department of Health – Office of Public Health
STD/HIV Program

General Instructions

1. Mark only one box per question unless otherwise noted.
2. Boxes should preferably be marked with an X.
3. Dates should be written in MM/DD/YYYY format. Months and days less than 10 should be preceded with a zero (0). For example, May should be recorded as 05. If the day is not known, record the known month and year values and record the day as 15. If the entire date is unknown, mark the *Unknown (Unk)* box with an X.
4. On all questions, unknowns should be marked with an X in the *Unknown (Unk)* box.
5. If a question is not applicable, mark the *N/A* box with an X.
6. All questions must be completed.
7. Include notes on questions that may need clarification.

Reporting Form Items

Report Date

- Date the form is completed and submitted to the STD/HIV Program

Reporting Facility

- Write in the facility that is reporting the diagnosis of HIV/Syphilis during pregnancy

Patient Information

- **Full Name:** Legal name, including middle name or initial if available in the following format: [First Name], [Last Name], [Maiden]
- **Address:** Most current address, if available in the following format: [Street Address],[Apartment/ Unit #], [City and Zip Code]
- Phone Number: Most current phone number for patient, if available.
- **2nd Phone number or Emergency Contact:** Patient's emergency contact information in the following format: [First Name], [Last Name], [Phone Number]
- **Date of Birth (DOB):** Patient's date of birth.
- **Date of Pregnancy Diagnosis:** Date the provider/facility confirmed pregnancy status of patient.
- **Estimated Delivery Date:** Date the patient is expected to deliver.

Linkage to Care

- **Disease Reporting:** Indicate if the patient is diagnosed with HIV, Syphilis, both, or other. For example, Hepatitis B (another reportable condition during pregnancy) can be reported here.
- **Prenatal Care:** Indicate if the patient is in prenatal care.
- **Syphilis:** If the patient is infected with syphilis, indicate which clinical stage; if the patient has been treated for the most current infection; and treatment dosage for the most recent infection.
- **HIV:** Indicate if the patient is currently on antiretroviral medication; and if she is engaged in HIV care.
- **Other Concerns for the Patient:** Indicate if there is any additional support the patient may need with an X next to all items that apply to the patient.
    - If other, write in the patient's specific needs.

Provider Information

- **Patient's Provider/Person Completing Form:** Write in the provider information or if this information is unavailable, write in the person that is completing the form that will be the point of contact between the reporting facility and the STD/HIV Program.
- **Phone Number:** Indicate if the most appropriate phone number for communication between the STD/HIV program and the reporting facility/provider.