



Maternal / Parental Patient Name: _____

Date of Birth: _____

HSN: _____

Due Date (EDC): _____

Recommendations from Maternal / Parental HIV Provider to Obstetrics and Pediatrics

** To be completed by Maternal / Parental HIV Provider and sent to Obstetrical Most Responsible Practitioner (MRP) prior to delivery**

This section contains information to aid the Maternal / Parental MRP in completing the HIV Positive Individuals in Labour INITIAL Medication and Care Orders [CS-OS-1801]

Seroconversion during pregnancy Yes No Unknown

Adherence / Management Concerns Yes No (If yes, write additional comments below.)

Maternal / Parental HIV viral loads prior to delivery:	Dates:

Scheduled caesarean section recommended (before onset of labour and rupture of membranes):

No, Not Required for HIV Management

Yes, Recommended

Criteria for caesarean section: HIV Viral Load at 34 to 36 weeks greater than 1,000 copies/mL or unknown, or possible lack of adherence since last HIV viral load.

The above criteria were met and caesarean section was recommended; this information was discussed with the obstetrical provider so that optimal management could be implemented; this conversation occurred on

_____ (date) with _____ (provider name).

This section contains information to aid the Newborn's MRP in completing the Infants Born to HIV Positive Individuals INITIAL Medication and Care Orders [CS-OS-5801]

Infant HIV Risk Category* (High/Intermediate/Low)	Communicated to Obstetrical Facility/Unit (list location(s) sent)	Date	Initials

***Re- Categorize infant to HIGH risk protocol if last HIV viral load is greater than 6 weeks prior to delivery**

Additional Comments for both sections:

Recommended by:

Maternal / Parental HIV Provider PRINTED NAME

Maternal / Parental HIV Provider SIGNATURE

Date

