SUPPLEMENTAL FORM FOR MOTHERS AND CHILDREN

A-MC

Demographics

1 **Patient's name:**

First Name | Middle Name | Last Name

UNIQUE IDENTIFIER CODE

2

First 2 letters of mother's real name	First 2 letters of father's real name	Birth Order	Month of Birth	Day of Birth	Year of Birth
☐☐	☐☐	☐☐	☐☐	☐☐	☐☐☐☐

FOR PREGNANT MOTHERS ONLY

Pregnancy History

M-1 **Number of Alive Children:** ☐☐

M-2

HIV Testing Status	Child #1	Child #2	Child #3	Child #4
HIV Status	☐ Positive ☐ Negative ☐ Don't know	☐ Positive ☐ Negative ☐ Don't know	☐ Positive ☐ Negative ☐ Don't know	☐ Positive ☐ Negative ☐ Don't know
Place Tested				
Date Tested				

M-3 **Last Menstrual Period** *(mm-dd-yyyy)* **:** ☐☐ - ☐☐ - ☐☐☐☐

M-4 **Number of months and weeks pregnant:** ☐☐ months and ☐☐ weeks

M-5 **Expected Date of Delivery** *(mm-dd-yyyy)* **:** ☐☐ - ☐☐ - ☐☐☐☐

M-6 **Where do you seek prenatal care?** _____ ☐ No prenatal clinic visit

M-7 **Where do you plan to deliver the baby?**

☐ Hospital, specify: _____ ☐ Home ☐ Others, specify: _____

☐ Lying-in clinic, specify: _____ ☐ No plans yet _____

Partner's HIV History and Tx

M-8 **Partner tested for HIV?**

☐ Yes, when *(mm-dd-yyyy)* ? _____ Facility? _____

Result: ☐ Positive ☐ Negative ☐ Don't know ☐ Did not get result

☐ No

☐ Don't know

M-9 **Partner taking ARV medication/s?** ☐ Yes ☐ No ☐ Don't know

☐ Stopped, (reason: _____)

FOR CHILDREN ONLY

Mother's HIV History

C-1 **Sex:** ☐ Male ☐ Female

C-2

Full name of mother:	**Full name of father:**
HIV Status: ☐ Positive ☐ Negative ☐ Don't know	**HIV Status:** ☐ Positive ☐ Negative ☐ Don't know
If positive, date of diagnosis (mm-dd-yyyy)? _____	**If positive,** date of diagnosis (mm-dd-yyyy)? _____
SACCL Code: _____	SACCL Code: _____
Status: ☐ Alive ☐ Dead (when? _____)	**Status:** ☐ Alive ☐ Dead (when? _____)

C-6 **Mother took ARV medication/s during pregnancy?** ☐ Yes,

☐ No, (reason: _____)

☐ Don't know

C-7 **Did mother breastfeed the baby?** ☐ Yes ☐ No

TO BE FILLED OUT BY SACCL PERSONNEL ONLY

HIV Testing Status

C-9 ☐ **PCR 1** Date: ☐☐ (Mo) - ☐☐ (Day) - ☐☐☐☐ (Year)

Result: ☐ Detected ☐ Not detected

C-10 ☐ **PCR 2** Date: ☐☐ (Mo) - ☐☐ (Day) - ☐☐☐☐ (Year)

Result: ☐ Detected ☐ Not detected

C-11 ☐ **PCR 3** Date: ☐☐ (Mo) - ☐☐ (Day) - ☐☐☐☐ (Year)

Result: ☐ Detected ☐ Not detected

Please send this accomplished form to hivregistry.nec@gmail.com or to National Epidemiology Center - Department of Health, 2/F Rm. 209 Building 19, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila.