



State of Louisiana

Louisiana Department of Health
Office of Public Health

HIV/SYPHILIS/HEP B/HEP C DURING PREGNANCY REPORTING FORM

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

REPORT DATE: _____ REPORTING FACILITY: _____

Patient Information	
Full Name	First Last Maiden
	Street Address Apartment/Unit #
Address	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 (Check all that apply):	<input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Hep B <input type="checkbox"/> HepC <input type="checkbox"/> Other _____
Is the patient engaged in OB and/or prenatal care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK	If the patient is currently infected with syphilis, what is the clinical stage of diagnosis? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early, Non-Primary/Secondary <input type="checkbox"/> Unknown/Late
Is the patient currently on antiretroviral therapy (ARVs) for HIV? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK <input type="checkbox"/> N/A	Has the patient been treated for the most recent infection of syphilis? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK <input type="checkbox"/> N/A
Is the patient currently engaged in HIV Care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK <input type="checkbox"/> N/A	If the patient was treated for a current syphilis infection, please record treatment and dosage: <input type="checkbox"/> 2.4 MU benzathine penicillin <input type="checkbox"/> 4.8 MU benzathine penicillin <input type="checkbox"/> 7.2 MU benzathine penicillin <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A
Date of Syphilis Treatment: ____/____/____	
Are you concerned about any of the following with your patient? Check all that apply. <input type="checkbox"/> Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Nutrition/Food Assistance <input type="checkbox"/> Med Adherence <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> None <input type="checkbox"/> Intimate Partner Violence (IPV) <input type="checkbox"/> Other (please specify): _____	

Provider Information	
Patient's Provider/Person Completing Form	
Phone Number	

Report diagnosis of HIV/syphilis/Hep B/Hep C 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) 568-7047

Confidential Fax: (504) 568-8384

Mail (completed forms must be mailed in a sealed envelope marked "Confidential"):

1450 Poydras Street, Suite 2136, New Orleans, LA 70112

STD/HIV PROGRAM • 1450 Poydras St., Suite 2136 • New Orleans, Louisiana 70112

Phone #: 504/568-7474 • Fax #: 504/568-7044 • WWW.DHH.LA.GOV

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