

**SUPPLEMENTAL FORM FOR MOTHERS AND CHILDREN****A-MC**

Demographics	1	Patient's name: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="border: 1px solid black; width: 20%; text-align: center;">First Name</div> <div style="border: 1px solid black; width: 20%; text-align: center;">Middle Name</div> <div style="border: 1px solid black; width: 20%; text-align: center;">Last Name</div> </div>					
	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	HIV Status	Child #1	Child #2	Child #3	Child #4
				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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? _____ <input type="checkbox"/> No prenatal clinic visit						
M-7	Where do you plan to deliver the baby? <input type="checkbox"/> Hospital, specify: _____ <input type="checkbox"/> Home <input type="checkbox"/> Others, specify: _____ <input type="checkbox"/> Lying-in clinic, specify: _____ <input type="checkbox"/> No plans yet _____						
Partner's HIV History and Tx	M-8	Partner tested for HIV? <input type="checkbox"/> Yes, when (mm-dd-yyyy)? _____ Facility? _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know <input type="checkbox"/> Did not get result <input type="checkbox"/> No <input type="checkbox"/> Don't know					
	M-9	Partner taking ARV medication/s? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Stopped, (reason: _____)					
FOR CHILDREN ONLY							
Mother's HIV History	C-1	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female					
	C-2	Full name of mother: _____		Full name of father: _____			
		HIV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know If positive, date of diagnosis (mm-dd-yyyy)? _____ SACCL Code: _____		HIV Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't know If positive, date of diagnosis (mm-dd-yyyy)? _____ SACCL Code: _____			
		Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead (when? _____)		Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead (when? _____)			
C-6	Mother took ARV medication/s during pregnancy? <input type="checkbox"/> Yes, <input type="checkbox"/> No, (reason: _____) <input type="checkbox"/> Don't know						
C-7	Did mother breastfeed the baby? <input type="checkbox"/> Yes <input type="checkbox"/> No						
TO BE FILLED OUT BY SACCL PERSONNEL ONLY							
HIV Testing Status	C-9	<input type="checkbox"/> PCR 1 Date: □ □ - □ □ - □ □ □ □ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Mo Day Year </div> Result: <input type="checkbox"/> Detected <input type="checkbox"/> Not detected					
	C-10	<input type="checkbox"/> PCR 2 Date: □ □ - □ □ - □ □ □ □ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Mo Day Year </div> Result: <input type="checkbox"/> Detected <input type="checkbox"/> Not detected					
	C-11	<input type="checkbox"/> PCR 3 Date: □ □ - □ □ - □ □ □ □ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Mo Day Year </div> Result: <input type="checkbox"/> Detected <input type="checkbox"/> 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.