** MN Perinatal HIV Program | Delivery Plan**

**Plan Date:**       **Update:**

***\*Confidentiality surrounding patient’s diagnosis is very important.*** Please discuss HIV diagnosis/treatment with her alone and establish to whom, if anyone, she has disclosed her HIV status. ***Additional NOTE:***

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| **Name:** |       | **DOB:** |       | **Due Date:** |       |
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| **Planned Mode of Delivery:** | [ ]  **Vaginal:** Spontaneous labor [ ]  **Vaginal:** Induction date/time:      a |
|  | [ ]  **C-Section** date/time:       a |
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| **Hospital Planned for Delivery:**       |
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| **OB/GYN Physician:**       | **Phone:**       | **Other:**       |
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| **ID Physician:**       | **Phone:**       | **Other:**       |
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| **Current HIV Medications & Dosing:** |       |
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| **Recent Lab Results** |  |  |  |  |
| **Date** |       |       |       |       |
| **Viral Load** |       |       |       |       |
| **CD4 count (T-cell)** |       |       |       |       |
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| **Standard Maternal Medications for Delivery:** |
| * **If Viral Load <1000 copies/mL:** Oral HIV medications as prescribed. IV Zidovudine (AZT, ZDV) not required.
* **If Viral Load >1000 copies/mL:** Oral HIV medications as prescribed. IV Zidovudine (AZT, ZDV) recommended.
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| **Patient and Provider Decision:** |
| [ ] [ ]  | Do **not** use IV Zidovudine (AZT, ZDV)**Use** IV Zidovudine (AZT, ZDV) |

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|  | **Zidovudine** (AZT, ZDV) **2mg/kg IV loading dose over an hour, then 1 mg/kg/hr** continuous infusion until delivery. *(Goal: minimum of 3 hrs before delivery, no max time limit.)* **If on Combivir:** hold Combivir during IV AZT administration, give Lamivudine 150 mg bid. |

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| **Additional medications/orders:** |       |
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| **Newborn Medications:** | **Zidovudine** (ZDV, AZT) syrup **4mg/kg po q 12 hrs beginning as soon as possible** and definitely by 6-12 hrs of age, continuing for a total of 6 weeks. *(Dose adjustments are warranted for premature infants* ***less than 35 weeks gestation****, or if any IV therapy is needed. Please contact pediatric ID consultation for adjusted orders if needed.)* |

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| **Additional medications/orders:** | **FORMULA FEEDING ONLY.**       |
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| ***NOTE:*** Please discharge pt with **at least 2 wks+** pediatric syrup; it is not easily available at community pharmacies. **Infant will need to complete full 6£ weeks of Zidovudine.** **£** Recommend any changes to length of ZDV treatment be determined by a pediatric infectious disease specialist, experienced in HIV, within the first weeks of life. |
| **Community Pharmacy** (if needed)**:** |       |
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| **Newborn Labs at Birth:** | CBC with diff and plts |
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| **Newborn Follow-up:** |
| 2 week HIV PCR screening | **Pediatric ID clinic:**       | **Phone:**       |
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| Well Child Care | **Clinic:**       | **Phone:**       |
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| ***NOTE: Please call the Perinatal Nurse Coordinator following delivery to help arrange for HIV screening apts.*** |
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| **For consultation:** Please contact Dr. Laura Hoyt, Pediatric ID Consultant, Children’s Hospitals & Clinics of MN |
|  | **Physician Access Line:**  | 612-343-2121 | **Natl. Perinatal Hotline:** 1-888-448-8765 |
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| ***\*\*Please FAX mom’s L&D records & newborn’s nursery record to the Perinatal HIV Nurse Coordinator for follow-up, including mandatory state reporting, at 651-220-7233*** |