High-Risk Pregnancy Notification Form

Miami-Dade County Health Department Perinatal

Please send confidential fax to: 305-470-5533

Required Reporting Information (per Florida Statute: 64D-3.042)

Newly Diagnosed: □ YES □ NO

Today's Date: _____

Facility Name: _____

Physician Name: _____

Office Chart ID/ File #: _____

Gravida/Para: _____

Estimated Delivery Date: _____

Hospital Name (delivery location): _____

Medication Prescribed: □Yes □ No **Date Prescribed:** _____

Referred to Infectious Disease Specialist/ Perinatologist: □ Yes □ No

Reporter (contact person): _____ **Reporter Telephone:** _____

Instructions: Please place this form in the patient's office chart and fax to the Miami-Dade County Health Department HIV Perinatal Coordinator within two weeks of diagnosis. Do NOT include patient names. Medical record numbers are required. If you have questions, please contact the HIV Perinatal Coordinator at 305-470-5672. This form does NOT eliminate reporting by submitting a complete Adult HIV/AIDS Confidential Case Report form to Miami-Dade County Health Department HIV/AIDS Surveillance. If you need assistance with reporting, please contact the HIV/AIDS Surveillance Supervisor at 305-470-5631.