



## Perinatal Hepatitis B Intake Form

Fax to 517/335-9855 or call 517/335-8122 or 800/964-4487 or in southeast Michigan  
 Fax to 313/456-0639 or call 313/456-4432

Woman's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Grav \_\_\_\_\_ Para \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 County \_\_\_\_\_ Telephone # \_\_\_\_\_ Emergency contact name & # \_\_\_\_\_  
 Race:  Asian/PI  Black  White  Amer Indian  Alaskan Native  Other \_\_\_\_\_  Unknown  
 Ethnicity:  Hispanic  Non-Hispanic  Unknown Country of Birth \_\_\_\_\_ Interpreter needed  Y  N  
 If yes, what language \_\_\_\_\_ Maternal Grandmother's Country of Birth \_\_\_\_\_  
 Mom's Insurance  Private  Medicaid  Uninsured  Unknown

### Woman's Laboratory Reports:

(P = Positive/Reactive; N = Negative/non-reactive; NT = Not tested; U = Unknown)

**HBsAg** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U      **Repeat HBsAg** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U

Date HBsAg reported \_\_\_/\_\_\_/\_\_\_ How reported: Lab-Electronic/Paper    OB    Hospital    Other \_\_\_\_\_

**HBeAg** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U      **HBeAb** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U

**Anti-HBc IgM** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U      **Anti-HBc** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U

**HBV DNA** \_\_\_/\_\_\_/\_\_\_  P  N  NT  U      **HBV Viral Load** \_\_\_\_\_      **Genotype** \_\_\_\_\_

Other maternal infections/conditions (HCV, HIV, Other STIs, etc) \_\_\_\_\_

LHD refer for care/evaluation?  Y  N  U      Hep B treatment during this pregnancy?  Y  N  U

If yes, treatment brand/dose \_\_\_\_\_ Treatment start date \_\_\_/\_\_\_/\_\_\_

Physician providing treatment \_\_\_\_\_ Telephone # \_\_\_\_\_

### Prenatal Care Provider (PCP) Information:

PCP/facility name \_\_\_\_\_ EDC date \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

Hospital to deliver \_\_\_\_\_ Reporting information sent to PCP  Y  N    Date \_\_\_/\_\_\_/\_\_\_

### Household/Sexual Contact Information:

First/Last Name (relationship)	DOB	HBIG	Hep B #1	Hep B #2	Hep B #3	HBsAg, anti-HBs and/or anti-HBc results	Test Date
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /
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Contact's provider name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

CD Nurse \_\_\_\_\_ Telephone # \_\_\_\_\_