



# 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 313/456-4427 or call 313/456-4432

Woman's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Telephone # \_\_\_\_\_ Emergency contact name & # \_\_\_\_\_

Race: Asian/PI Black White Amer Indian Alaskan Native Other \_\_\_\_\_ Unknown

Ethnicity: Hispanic Non-Hispanic Unknown

Grav \_\_\_\_ Para \_\_\_\_ Country of Birth \_\_\_\_\_ Maternal Grandmother's Country of Birth \_\_\_\_\_

Does the woman need an interpreter  Y  N If yes, what language \_\_\_\_\_

### 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 \_\_\_\_\_

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 at \_\_\_\_\_

Reporting information sent to PCP office?  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
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /

Household/sexual contact provider name \_\_\_\_\_

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

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