Perinatal Hepatitis B Intake Form

Fax to 517-335-9855 or call 517-284-4893 or 800-964-4487 or in Southeast Michigan
Fax to 313-456-0639 or call 313-456-4432

Mom's name _____ Date of birth _____ MDSS # _____

Address _____ City _____ Zip _____ County _____

Telephone # _____ Emergency contact name & # _____ Grav _____ Para _____

Race: ☐ Asian/PI ☐ Black ☐ White ☐ Amer Indian ☐ Alaska Native ☐ Other _____ ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Method of Delivery ☐ Vaginal ☐ Cesarean

Mom's Country of Birth _____ Interpreter Needed ☐ Y ☐ N If Yes, Language _____

Mom's Insurance ☐Private ☐Medicaid ☐Uninsured ☐County Health Plan ☐Medicare ☐Military (Tricare) ☐Unknown

(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: Electronic Paper Lab 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** _____ ***Unit* Type** _____

Other Infections/Conditions **(HCV, HIV, Syphilis, Other STIs, etc)** _____

Mom Being Monitored for HBV? ☐ Y ☐ N ☐ U Mom Being Treated for HBV? ☐Y ☐N ☐U

If yes, please indicate:	Start Date	End Date	Reported By
Treatment Type _____	__/__/__	__/__/__	☐ *Mom History* ☐ *Med Record* ☐ *Other* _____
Treatment Type _____	__/__/__	__/__/__	☐ *Mom History* ☐ *Med Record* ☐ *Other* _____

Physician Monitoring/Providing Treatment _____ Telephone # _____

Mom Get Tdap ***(this pregnancy)*** ☐Y ☐N Date ___/___/___ Flu ***(this pregnancy)*** ☐Y ☐N Date ___/___/___ Doses in MCIR ☐Y ☐N

Prenatal Care Provider (PCP) Information:

PCP/Facility Name _____ EDC Date ___/___/___ Telephone # _____

Address _____ City _____ Zip _____

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
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /

Contact's Provider Name _____ Address _____

City _____ Zip _____ Telephone # _____

CD Nurse _____ Telephone # _____