

Date:

OB Name
Address
Address

Dr. and Associates:

The primary goal of the Perinatal Hepatitis B Prevention Program is to identify all women who test positive for hepatitis B surface antigen (HBsAg) **prenatally** so that their newborns can receive the appropriate prophylaxis. It is very important that prenatal care providers test every pregnant woman, for every pregnancy, even if they have been previously vaccinated or tested. If the pregnant woman is HBsAg-positive, these results need to be reported to both the local health department (LHD) and to the delivering hospital staff.

Our program provides case management for all women who test positive for hepatitis B prenatally. As part of case documentation, I am requesting the following information for this patient: **{{ Name and DOB}}**

Patient's race/ethnicity? _____ Patient's country of birth? _____
Patient's mother's country of birth? _____
Language spoken (if other than English)? _____ Expected due date? _____
Expected delivery hospital? _____ Grav _____ Para _____

Other hepatitis B labs on record after **{{date of 1st labs}}**

(P = Positive/Reactive; N = Negative/Non-Reactive; NT = Not Tested; U = Unknown)					
HBsAg	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> NT <input type="checkbox"/> U	Repeat HBsAg	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> NT <input type="checkbox"/> U
HBeAg	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> NT <input type="checkbox"/> U	HBeAb	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> NT <input type="checkbox"/> U
HBV DNA	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> NT <input type="checkbox"/> U	HBV Viral Load	_____	Genotype _____

Other maternal infections/conditions **(HCV, HIV, Syphilis, Other STIs, etc)** _____

Has patient been referred for care? Yes or No (circle one)

Is patient being treated for HBV? Yes or No (circle one)

If yes, treatment date _____ Brand/dose _____

Physician providing treatment _____ Telephone: _____

Patient's insurance: _____

Did patient receive influenza vaccination during this pregnancy? Yes or No (circle one) Date given: _____

Did patient receive Tdap vaccination during this pregnancy (recommended at 27-36 weeks)?

Yes or No (circle one) Date given: _____ ****Please enter the above doses in the Michigan Care**

Improvement Registry (MCIR). If your office would like to be contacted about MCIR, check this box

Please make sure your staff is aware of this important process.

For additional information, go to the OB/GYN section of our program manual at www.michigan.gov/hepatitisB. Also, please refer your clients to the new MOM page included in the program manual.

Sincerely,

Perinatal Hepatitis B Program Case Manager
Fax to: 517-335-9855 or call 517-335-8122
Or in SE MI Fax to: 313-456-0639 or call 313-456-4432