

Perinatal Hepatitis B Intake Form
Fax to 517-763-0470; or call 517-388-4815, 517-897-3236 or 517-242-8319

Pregnant person'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
 Pregnant person's Country of Birth _____ Interpreter Needed Y N If Yes, Language _____
 Pregnant person's Insurance Private Medicaid Uninsured Co 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**) _____

Pregnant person being monitored for HBV? Y N U Pregnant person being treated for HBV? Y N U

If yes, please indicate: Start Date End Date Reported By

Treatment Type _____ / / / / **History** **Med Record** **Other** _____

Treatment Type _____ / / / / **History** **Med Record** **Other** _____

Physician Monitoring/Providing Treatment _____ Telephone # _____

Preg person rec'd 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 # _____
 Fax # _____ 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 # _____ Fax # _____
 CD Nurse _____ Telephone # _____ Fax # _____

DCH-1398 (Rev. 06/23) Michigan Department of Health & Human Services (MDHHS) AUTHORITY: PA 368 of 1978, as amended.

MDHHS does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.