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 # _____