



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR PUBLIC HEALTH**

**Steven L. Beshear**  
Governor

275 East Main Street, HS2GW-C  
Frankfort, Kentucky 40621  
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**Audrey Tayse Haynes**  
Secretary

December 18, 2013

Dear Healthcare Provider,

The Kentucky Department for Public Health is requesting your assistance to help us estimate the number of pregnant women and children aged five years and less who are infected with hepatitis C virus (HCV), and seen in birthing hospitals, medical practices, and clinics throughout the Commonwealth. The Kentucky Adult Viral Hepatitis Prevention Program has been conducting a pilot test of HCV laboratory testing at selected local health departments for the last two years. The pilot testing sites have reported an increase in confirmed HCV-positive tests among individuals aged 20 through 29 years. A concern is that this age group includes women of child bearing ages where potential HCV transmission to the infant/child could occur if the pregnant woman was HCV infected.

In Kentucky, only acute hepatitis C cases are normally required to be reported. Starting January 1, 2014 through March 31, 2014, we are asking for healthcare providers to voluntarily report: 1) all HCV-positive pregnant women; 2) all infants born to HCV-positive women; and 3) all HCV-positive infants and children aged five years or less seen in birthing hospitals, medical practices, and clinics, in addition to the current hepatitis B infection reporting requirements in these populations. To report any HCV-positive individuals in the above categories during this time period, please complete the attached reporting form and fax to the Kentucky Department for Public Health at: 502-564-4760.

We deeply appreciate your time and effort in assisting us with this active surveillance project for perinatal HCV infections. If you have additional questions or concerns, please call Kathy Sanders, RN, MSN at 502-564-3261, ext. 4236 or Julie Miracle, RN, BSN at 502-564-4478, ext. 4260.

*Robert L. Brawley, MD, MPH*

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275 East Main Street, MS: HS2GW-C  
Frankfort, KY 40621-0001



# Kentucky Reportable Disease Form

Department for Public Health  
 Division of Epidemiology and Health Planning  
 275 East Main St., Mailstop HS2E-A  
 Frankfort, KY 40621-0001

**Hepatitis Infection in a Pregnant Woman, Infant, or Child (aged five years or less)**  
 Fax Form to 502-564-4760

| DEMOGRAPHIC DATA    |       |              |                   |  |  |
|---------------------|-------|--------------|-------------------|--|--|
| Patient's Last Name | First | M.I.         | Date of Birth     | Age  | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk   |
| Address             |       |              | City              | State  | Zip  |
| County of Residence |       | Phone Number | Patient ID Number | Ethnic Origin<br><input type="checkbox"/> Hisp. <input type="checkbox"/> Non-Hisp. | Race<br><input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other |

| DISEASE INFORMATION   |                                   |   |                           |
|---|-----------------------------------|---|---------------------------|
| Describe Clinical Symptoms:   | Date of Onset:<br>/ /             | Jaundice:<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Diagnosis:<br>/ / |
| Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # wks _____ | Expected Date of Delivery:<br>/ / | Name of Hospital for Delivery:  |                           |
| Physician Provider Name:<br>Address:<br>Phone:  |                                   |   |                           |

| LABORATORY INFORMATION |   |              |                              |                    |
|------------------------|---|--------------|------------------------------|--------------------|
| Hepatitis Markers      | Results   | Date of test | Viral Load<br>*if applicable | Name of Laboratory |
| HBsAg                  | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |
| IgM anti-HBc           | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |
| HBeAg                  | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |
| IgM anti-HAV           | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |
| HCV Antibody           | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |
| HCV RNA Confirmation   | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | / /          |                              |                    |

| SERUM AMINOTRANSFERASE LEVELS |           |              |                    |
|-------------------------------|-----------|--------------|--------------------|
| Patient                       | Reference | Date of test | Name of Laboratory |
| AST (SGOT) U/L                | U/L       | / /          |                    |
| ALT (SGPT) U/L                | U/L       | / /          |                    |

|   |  |
|---|--|
| Mother: Hepatitis Risk Factors<br><input type="checkbox"/> IDU <input type="checkbox"/> Multiple Sexual Partners <input type="checkbox"/> Tattoos <input type="checkbox"/> STD<br><input type="checkbox"/> HIV <input type="checkbox"/> Foreign Born/ Country _____<br><input type="checkbox"/> Exposure to known HBV/HCV Pos contact | Child: Hepatitis Risk Factors<br><input type="checkbox"/> Mother HBV Pos <input type="checkbox"/> Household member exposure HBV Pos<br><input type="checkbox"/> Mother HCV Pos <input type="checkbox"/> Household member exposure HCV Pos<br><input type="checkbox"/> Foreign Born / Country _____ |
|---|--|

Mother: Hepatitis A vaccination history:  Yes  No  Refused Dates Given: \_\_\_\_\_  
 Hepatitis B Vaccination history:  Yes  No  Refused  
 If yes, how many doses  1  2  3 Year completed: / /  
 Child: Hepatitis A vaccination history:  Yes  No  Refused Dates Given: \_\_\_\_\_  
 Hepatitis B Vaccination history:  Yes  No  Refused Dates Given: \_\_\_\_\_  
 Was PEP for Infant of Positive HBV mother given at birth?  Yes  No

