



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 Pregnant Women or Child (aged five years or less)

Report HBV electronically in NEDSS or by fax using EPID 394. Report HCV electronically or by fax using EPID 394.

Fax reports to 502-564-4760

Date Report Submitted:

Agency Report Submitted by:

Agency Contact Phone Number:

NEWBORN INFANT BORN TO MOTHER WITH HBV/HCV or CHILD AGED 5 AND UNDER WITH HBV/HCV															
Infant/ Child: Last Name			First		M.I.	Date of Birth		Gender Male Female		Neonatal Abstinence Syndrome Yes No Not known		HBV vaccination given at birth: Yes No Not known			
Address				City		State		Zip		County of Residence		Infant/Child lives with: Mother Foster Parent Adopted Other: _____			
Infant/Child Medical Record #		Ethnic Origin Hispanic Non-Hispanic		Race: * W B A AI PI			Birth weight: lbs. oz.		Mother's Current Legal Last Name:			First M.I.			
PREGNANT/ POST PARTUM MOTHER INFORMATION															
Current Legal Last Name: First			M.I.		Maiden		Is Patient Pregnant? Yes No Expected Date of Delivery: / /			Is Patient Post-Partum? Yes No If yes, date of delivery: / /			Mother's Medical Record #		
Address				City		State		Zip		Ethnic Origin: Hispanic Non-Hispanic		Social Security #		Name of Physician/Hospital for Delivery:	
County:		History of Incarceration: Yes No Not known			Race: * W B A AI PI							Address:			
WOMEN/ POST PARTUM OR CHILD LABORATORY INFORMATION															
Hepatitis Markers		Results			Date of test		Viral Load (If applicable)		Name of Laboratory						
HBsAg		Pos	Neg	Unknown	/ /										
IgM anti-HBc		Pos	Neg	Unknown	/ /										
HBeAg		Pos	Neg	Unknown	/ /										
IgM anti-HAV		Pos	Neg	Unknown	/ /										
HCV Antibody ** See below		Pos	Neg	Unknown	/ /										
HCV RNA Confirmation *** See below		Pos	Neg	Unknown	/ /										
SERUM AMINOTRANSFERASE LEVELS															
Mother or Child		Reference			Date of test		Name of Laboratory								
AST (SGOT)		U/L			/ /										
ALT (SGPT)		U/L			/ /										
Mother: Hepatitis Risk Factors:															
IV Drug Use		Yes	No	Unknown	Intranasal Drug Use		Yes	No	Unknown	Tattoos		Yes	No	Unknown	
STI History		Yes	No	Unknown	HIV		Yes	No	Unknown	Foreign Born? Country: _____					
Multiple Sex Partners		Yes	No	Unknown	HCV Contact Exposure		Yes	No	Unknown						
Child: Hepatitis Risk Factors:															
Mother HBV Pos		Yes	No	Unknown	HBV Contact Exposure		Yes	No	Unknown	Foreign Born? Country: _____					
Mother HCV Pos		Yes	No	Unknown	HCV Contact Exposure		Yes	No	Unknown						
Mother Or Child Vaccination History:															
Hepatitis A vaccination history: Yes No Unknown Refused Date Given: / /															
Hepatitis B Vaccination history: Yes No Unknown Refused If yes, how many doses 1 2 3 Dates completed: / /															
For Infants born to mothers with HBV, was HBIG given: Yes No Unknown Date Given: / /															
* Race: W-White B-Black A-Asian AI- American Indian or Alaska Native PI-Pacific Islander															
** HCV Antibody should not be performed at birth, due to presence of maternal antibodies. Wait until at least 18 months of age															
*** HCV RNA Confirmation is recommended for infants born to mothers with HCV infection. KY DPH recommends HCV RNA Confirmation at 2 month or 4 month well child visit.															

Note: If exhibiting signs and symptoms of HCV, report using the EPID 200

