EPID 394
Revised 7/2024

# Kentucky Reportable Disease Form

**Department for Public Health, Division of Epidemiology and Health Planning**
**275 East Main St., Mailstop HS2E-A**

**Hepatitis Infection in Pregnant Women or Child (HBV- aged two years or less & HCV- aged three years or less)**
**Report HBV/HCV electronically or by fax using EPID394.**
**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 ≤ 2 for HBV and ≤ 3 for HCV

| Infant/ Child: Last Name First M.I. | Date of Birth: / / | Gender: Male ☑ Female ☐ | Neonatal Abstinence Syndrome: Yes ☐ No ☐ Unknown ☑ | HBV Vaccine Given at Birth: Yes ☐ No ☐ Unknown ☑ |
|---|---|---|---|---|
| Address: City: State: Zip: County of Residence: | | | Infant/Child lives with: Other<br>Mother Foster Parent Adopted Other: _____ | |
| Infant/ Child Medical Record #: | Ethnic Origin: Non-Hispanic<br>Hisp. Non-Hisp. | Race: Pacific Islander<br>* W B A AI PI | Birth Weight: lbs. oz. | Mother's Current Legal Last Name: First: M.I. |
| Insurance Status: Unknown<br>Private Medicaid Uninsured Unknown | Is the Department Community Based Services Involved: ☐Yes No ☐<br>If Yes, Case Number: _____ | | Guardian's Name/ Telephone Number: | |

## PREGNANT/ POST PARTUM MOTHER INFORMATION

| Current Legal Last Name: First: M.I.: Maiden: | Is Patient Pregnant: Yes ☐ No ☐<br>Expected Date of Delivery: / / | Is Patient Post-Partum ☐Yes No ☐<br>If yes, Date of Delivery: / / | Date of Birth: / / | |
|---|---|---|---|---|
| Address: City: State: Zip: County of Residence: | Ethnic Origin: Non-Hispanic<br>Hisp. Non-Hisp. | Race: Pacific Islander<br>* W B A AI PI | Telephone Number: | |
| Mother's Medical Record #: | Social Security #: - - | History of Incarceration: Yes ☐ No ☐ Unknown ☑ | Name of Physician / Hospital for Delivery:<br>Address: | |

## WOMAN/ POST PARTUM OR CHILD LABORATORY INFORMATION

| Hepatitis Markers | Results | Date of Test | Viral Load (if applicable) | Name of Laboratory | Mother or Child: |
|---|---|---|---|---|---|
| HBsAg | Pos Neg Unk Unknown | / / | | | |
| HB Surface anti-HBs | Pos Neg Unk Unknown | / / | | | |
| IgM anti-HBc | Pos Neg Unk Unknown | / / | | | |
| HBeAg | Pos Neg Unk Unknown | / / | | | |
| IgM anti-HAV | Pos Neg Unk Unknown | / / | | | |
| HCV Antibody ** See Below | Pos Neg Unk Unknown | / / | | | |
| HCV RNA Confirmation ** See Below | Pos Neg Unk Unknown | / / | | | |

## SERUM CAINOTRANSFERASE LEVELS

| Mother or Child: | Reference: | Date of Test: | Name of Laboratory: |
|---|---|---|---|
| AST (SGOT) U/L | U/L | / / | |
| ALT (SGPT) U/L | U/L | / / | |

### Mother Hepatitis C Risk Factors:

IV Drug Use Yes No Unknown Unknown Internasal Drug Use Yes No Unk Unknown Tattoos Yes No Unknown Unknown
STI History Yes No Unknown Unknown HIV Yes No Unk Unknown Foreign Born? Country: _____
Multiple Sex Partners Yes No Unknown Unknown HCV Contact Exposure Yes No Unk Unknown

### Child Hepatitis B or C Risk Factors:

Mother HBV Positive Yes No Unknown Unknown HBV Contact Exposure Yes No Unknown Unknown
Mother HCV Positive Yes No Unknown Unknown HCV Contact Exposure Yes No Unknown Unknown

### Mother Vaccination History:

Hepatitis A Vaccination History: Yes No Unknown Refused Refused
Hepatitis B Vaccination History: Yes No Unknown Refused Refused
If Yes, how many doses ☐1 ☐2 ☑3 Dates Completed: Dose 1: / / Dose 2: / / Dose 3: / /

### Child Vaccination History:

Hepatitis A Vaccination History: Yes No Unknown Refused Refused
Hepatitis B Vaccination History: Yes No Unknown Refused Refused
If Yes, how many doses ☐1 ☐2 ☑3 Dates Completed: Dose 1: / / Dose 2: / / Dose 3: / /
Infants born to mothers with HBV, was HBIG given: ☐Yes ☐No ☑Unknown If Yes, 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 for infant, due to presence of maternal antibodies. HCV antibody testing with reflex RNA testing at ≥ 18 months.
*** HCV RNA confirmation is recommended for infants born to mothers with an active HCV infection. KY DPH and CDC recommends NAT for HCV RNA at 2-6 months.
If interested in reporting electronically, please reach out to KHIEsupport@ky.gov on how to enroll in the direct data entry for hepatitis reporting.