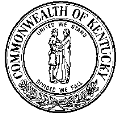
EPID 394



Revised April 2018

**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  Hisp. Non-Hisp. | | | 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 Add field for date of birth | | | | | | | | 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 ZipAdd field for telephone number | | | | | | | | | | Ethnic Origin:  Hisp. Non-Hisp. Race:  \* W B A AI PI | | | | | Social Security # | | Name of Physician/ Hospital for Delivery:  Address: | | |
| County: | History of Incarceration: Yes No Not known | | | | | | | | |
| WOMEN/ POST PARTUM OR CHILD LABORATORY INFORMATION | | | | | | | | | | | | | | | | | | | |
| **HepatitisMarkers** | | | **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 | | | | U/L | | / / | | | | | | |  | | | | | | |
| ALT (SGPT) U/L | | | | 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  \*\* HCVAntibody 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**

