EPID 394 Revised December 2023

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 Form to Residing Health Department or 502-696-3803 or 855-568-8601

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

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	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

** 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