Perinatal Hepatitis B Intake Form

Fax to 517/335-9855 or call 517/335-8122 or 800/964-4487 or in southeast Michigan
Fax to 313/456-4427 or call 313/456-4432

Woman's name _____ Date of birth _____ Social Security # _____

Address _____ City _____ Zip _____

County _____ Telephone # _____ Emergency contact name & # _____

Race: Asian/PI Black White Amer Indian Alaskan Native Other _____ Unknown

Ethnicity: Hispanic Non-Hispanic Unknown

Grav ____ Para ____ Country of Birth _____ Maternal Grandmother's Country of Birth _____

Does the woman need an interpreter ☐ Y ☐ N If yes, what language _____

Woman's Laboratory Reports:

(P = Positive/Reactive; N = Negative/non-reactive; NT = Not tested; U = Unknown)

HBsAg ___/___/___ ☐ P ☐ N ☐ NT ☐ U **Repeat HBsAg** ___/___/___ ☐ P ☐ N ☐ NT ☐ U

Date HBsAg reported ___/___/___ How reported: Lab–Electronic/Paper OB Hospital Other _____

HBeAg ___/___/___ ☐ P ☐ N ☐ NT ☐ U **HBeAb** ___/___/___ ☐ P ☐ N ☐ NT ☐ U

Anti-HBc IgM ___/___/___ ☐ P ☐ N ☐ NT ☐ U **Anti-HBc** ___/___/___ ☐ P ☐ N ☐ NT ☐ U

HBV DNA ___/___/___ ☐ P ☐ N ☐ NT ☐ U **HBV Viral Load** _____

Other maternal infections/conditions **(HCV, HIV, Other STIs, etc)** _____

LHD refer for care/evaluation? ☐ Y ☐ N ☐ U Hep B treatment during this pregnancy? ☐ Y ☐ N ☐ U

If yes, treatment brand/dose _____ Treatment start date ___/___/___

Physician providing treatment _____ Telephone # _____

Prenatal Care Provider (PCP) Information:

PCP/facility name _____ EDC date ___/___/___

Address _____ City _____ Zip _____

Telephone # _____ Hospital to deliver at _____

Reporting information sent to PCP office? ☐ Y ☐ N Date ___/___/___

Household/Sexual Contact Information:

First/Last Name (relationship)	DOB	HBIG	Hep B #1	Hep B #2	Hep B #3	HBsAg, anti-HBs and/or anti-HBc results	Test Date
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /
	/ /	/ /	/ /	/ /	/ /		/ /

Household/sexual contact provider name _____

Address _____ City _____ Zip _____ Telephone # _____

CD Nurse _____ Telephone # _____