West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH

Hepatitis B Pregnancy Case Report Form

Patient Demographics (Mother)

Name: (last, first, middle): _____

Address (mailing): _____

Address (physical): _____

City/State/Zip: _____

County of Residence: _____

Birth Date: __ / __ / ____ Age: _____

Sex: Male Female Unknown

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown

Race (Mark all that apply): White Black/African American

Native Hawaiian or other Pacific Islander Other

Native American/Alaskan Native Asian Unknown

Investigation Summary

Investigation Start Date: __/__/____ Investigator: _____ Investigator Phone Number:

Report Source/Health Care Provider (HCP)

Report Source: Laboratory Hospital Private Provider Public Health Agency Other– Specify:

Clinical (Mother)

Primary HCP Name:

Primary HCP Phone number:

Y	N	U		Y	N	U	
☐			Is the Patient aware of their diagnosis? Diagnosis date: __/__/____				Is the Patient Symptomatic? Onset Date: __/__/____
			Was the person hospitalized?				Jaundice
			If yes, Hospital Name				Nausea
			Patient Chart Number _____ (if available)				Vomiting
			Admit Date_____ Discharge Date _____				Abdominal pain/right upper quadrant pain
			Did the patient die from this illness? If Yes, Date: __/__/____				Dark urine
			Is this patient pregnant? If Yes, Due Date: __/__/____				Clay colored stool
			Is this patient an insulin dependent diabetic?				Anorexia
			Symptoms of acute hepatitis				Malaise
			Screening of asymptomatic patient with reported risk factors				Headache
			Evaluation of elevated liver enzymes				Fever
			Follow-up testing for a previous marker of viral hepatitis				Negative Hepatitis B testing within 6 months?
			Blood/Organ donor screening				If yes, Date: __/__/____
			Prenatal Screening				Negative Hepatitis C testing within 12 months?
			Other, please specify				If yes, Date: __/__/____

Laboratory results (Mother)

ALT Result: _____ Upper Limit: ____Date: __/__/____ AST Result: ____ Upper Limit: ____ Date: __/__/____

Bilirubin result: Upper Limit: Date: / /

(+)	(-)	NA		(+)	(-)	NA	
			Total Antibody to hepatitis A virus (Total anti-HAV)				Antibody to hepatitis C virus (anti-HCV)
			IgM antibody to hepatitis A virus (IgM anti-HAV)				HCV RNA (Quantitative or Qualitative PCR)
			Hepatitis B surface antigen (HBsAg)				HCV Genotype
			Hepatitis B 'e' antigen (HBeAg)				HCV Antigen
			Total antibody to hepatitis B core antigen (Total anti-HBc)				Antibody to hepatitis D virus (anti-HDV)
			IgM antibody to hepatitis B core antigen (IgM anti-HBc)				HDV RNA (Quantitative or Qualitative PCR)
			HBV DNA				Antibody to hepatitis E virus (anti-HEV)
			HEV antibody				HEV RNA

Delivery Information

Estimated Due Date: __/__/____

Y N U

Is the patient receiving prenatal care?

OBGYN Name:

Mother Information

Y N U

Mother aware of HBV Infection prior to pregnancy?

Has the mother been referred to treatment?

Infectious disease specialist: Phone:

Birthing Facility Information

Planned Delivery Facility:

Facility Contact Person:

Facility Contact Person Phone:

Y N U

Facility educated regarding HBIG and Vaccine information?

Date information was provided: __/__/____

Complications:

Birth Information

Pregnancy Outcome:

Method of Delivery:

Infant Date of Birth: __/__/____

Time of Birth: __:__

Birth Weight (grams): _____

Gestation:

Sex of infant:

HBIG Information

Y N U

Was the infant given HBIG? Date: __/__/____

Was HBIG given within 12 hours of birth?

Vaccination Information

Y N U

Has the infant been given HBV Vaccine?

Was the first HBV vaccine dose within 12 hours of birth?

Vaccine Dose 1 Date: __/__/____

Vaccine Dose 2 Date: __/__/____

Vaccine Dose 3 Date: __/__/____

Vaccine Dose 4 Date: __/__/____

Pediatrician Information

Pediatrician Name:

Pediatrician Address:

Pediatrician Phone:

Post Vaccination Testing

Y N U

Was the child tested for anti-HBs after vaccination?

Date: / / Result:

Was the child tested for HBsAg more than 30 days after last vaccination dose? Date: / / Result:

Comments: