Hepatitis B Infected Infants Supplemental Form

California Dept. of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (916) 440-5973

Complete this section of form before contacting prenatal care provider

Infant's name (*last, first, middle initial)*	Infant DOB *(mm/dd/yyyy)* / /	CalREDIE ID	PHPP ID ___-___-___-_____
Mother's name (*last, first, middle initial)*	Mother DOB *(mm/dd/yyyy)* / /	CalREDIE ID *(if applicable)*	

Prenatal Care Information

1. Who provided prenatal care during this pregnancy? (If >1 practice, list others at bottom of page)	1a. Prenatal care practice name/location	1b. Prenatal care phone number

Infant PEP Information

2. Did infant receive appropriate PEP at birth? ☐ Yes ☐ No	3. Did infant receive the complete HBV vaccine series in a timely way? ☐ Yes ☐ No

Contact prenatal care provider of mother of HBV-infected infant to complete rest of form

Mother's History

4. Did HBV-infected mother receive HBV DNA testing during this pregnancy as recommended by ACOG and CDC?
☐ Yes ☐ No

4a. If no, why not?
- ☐ Unaware of recommendation
- ☐ Ordered testing, but testing not done (if not done, why not done?)
- ☐ Other, specify: _____

If no, skip to question 6

4b. If yes, what was HBV DNA result?
☐ ≤20,000 IU/mL ☐ >20,000 IU/mL ☐ Unknown (try to obtain result)

5. If HBV DNA result >20,000 IU/mL, was mother referred to a hepatitis specialist as recommended by ACOG and CDC?
☐ Yes ☐ No

5a. If yes, name of specialist mother referred to? _____

5b. If yes, mother treated during pregnancy with antivirals? ☐ Yes ☐ No

5c. If yes, name of antiviral, dose and dates of treatment?

_____

5d. If no, why not?
- ☐ Unaware of recommendation
- ☐ Made referral, but mother did not seek care
- ☐ Other, specify: _____

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6. Did mother have HBeAg testing performed as recommended by ACOG and CDC?
☐ Yes ☐ No

6a. If no, why not?
☐ Unaware of recommendation
☐ Ordered testing, but testing not done (if not done, why not done?)
☐ Other, specify: _____

If no, skip to question 8

6b. If yes, what was HBeAg result?
☐ Positive ☐ Negative ☐ Unknown (try to obtain result)

7. If HBeAg test result was positive, was mother referred to a hepatitis specialist as recommended by ACOG and CDC?
☐ Yes ☐ No

7a. If yes, name of specialist mother referred to? _____

7b. If yes, mother treated during pregnancy with antivirals? ☐ Yes ☐ No

8. Did mother have ALT testing performed as recommended by ACOG and CDC?
☐ Yes ☐ No

8a. If no, why not?
☐ Unaware of recommendation
☐ Ordered testing, but testing not done (if not done, why not done?)
☐ Other, specify: _____

If no, skip to end of form

8b. If yes, what was ALT result?
☐ <19 IU/L ☐ ≥19 IU/L ☐ Unknown (try to obtain result)

9. If ALT test result was ≥19 IU/L, was mother referred to a hepatitis specialist as recommended by ACOG and CDC?
☐ Yes ☐ No

9a. If yes, name of specialist mother referred to? _____

9b. If yes, mother treated during pregnancy with antivirals? ☐ Yes ☐ No

9c. If yes, name of antiviral, dose and dates of treatment?

_____

Date form completed / /

Name of LHD staff member completing form _____

Name of prenatal care provider staff member interviewed _____