HBV DNA Results Form

Please complete and return this form by fax or email:

Fax: (213) 351-2781

Click to Email Form

SEND THIS FORM IF HBV DNA IS > 20,000 IU/mL OR if Patient is No Longer in Your Care

Patient's Name: _____ **DOB:** _____
(mm/dd/yyyy)

Please indicate the patient's HBV DNA status *(check one):*

☐ **HBV DNA detected >20,000 IU/mL**

Was patient referred to a specialist? ☐ **Yes (or already referred)** ☐ **No** ☐ **Unknown**

If **yes (or already referred)**, please provide the doctor's name and phone number:

Specialist's Name: _____

Phone Number: _____

If **no**, please indicate reason:

☐ **Prenatal care started late in the pregnancy**

☐ **Patient refused referral**

☐ **Other reason:** _____

☐ **HBV DNA detected >200,000 IU/mL**

Was patient evaluated by a specialist for antiviral therapy? ☐ **Yes** ☐ **No** ☐ **Unknown**

Has patient started antiviral therapy? ☐ **Yes (or already on antivirals)** ☐ **No** ☐ **Unknown**

If yes (or already on antivirals), please provide the antiviral medication name.

☐ Tenofovir disoproxil (TDF, Viread) ☐ Tenofovir alafenamide (TAF, Vemlidy)

☐ Other: _____ ☐ Unknown

If no, please indicate reason:

☐ **Prenatal care started late in the pregnancy**

☐ **Patient refused antiviral therapy**

☐ **Other reason:** _____

☐ **Patient is no longer in my care.**

New Obstetrician's Name (if known): _____

Phone Number: _____

Name of Physician Completing Form: _____

Phone Number: _____ **Email:** _____

Fax Number: _____ **Date Submitted:** _____

Revised 2026-07-10