EPID 394 Revised April 2018

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 reports to 502-564-4760

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 Zip Add field for telephone number	Ethnic Origin: Hisp. Non-Hisp.	Social Security #	Name of Physician/ Hospital for Delivery:
County: History of Incarceration: Yes No Not known	Race: * W B A AI PI		Address:

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
STI History Yes No Unknown
Multiple Sex Partners Yes No Unknown
Intranasal Drug Use Yes No Unknown
HIV Yes No Unknown
HCV Contact Exposure Yes No Unknown
Tattoos Yes No Unknown
Foreign Born? Country: _____

Child: Hepatitis Risk Factors:

Mother HBV Pos Yes No Unknown
Mother HCV Pos Yes No Unknown
HBV Contact Exposure Yes No Unknown
HCV Contact Exposure Yes No Unknown
Foreign Born? Country: _____

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

Kentucky UNBRIDLED SPIRIT