ISOSS hepatitis B positive antenatal notification

form date 03/21

CONFIDENTIAL

HOSPITAL NAME: HOSPITAL CODE:

PART 1: MATERNAL DETAILS

I. Demographic information

Date of birth: ____/____/____ **Soundex:** ……………

NHS no.: …………………………………… **Hospital no.:** ………………………………

GP name: ………………………………………………………… **Practice:** ………………………………………………….

Not registered at GP ☐

Ethnic origin:

White
☐ British
☐ Irish
☐ Any other White background

Black or Black British
☐ Caribbean
☐ African
☐ Any other Black background

Other Ethnic Groups
☐ Chinese
☐ Any other ethnic group

Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other mixed background

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background

☐ Not stated

Home postcode (leave off last letter): ☐☐☐☐ ☐☐■

Country of birth: ………………………………………… **If country of birth not UK, date of arrival:** ____/____/____

II. Social circumstances

Employment status at booking: ☐ Employed (full or part-time) ☐ Home ☐ Sick ☐ Student ☐ Unemployed ☐ Retired ☐ Voluntary ☐ Not known

Main support during pregnancy: ☐ Partner (cohabiting) ☐ Partner (not cohabiting) ☐ Family/friend ☐ Other ☐ None ☐ Not known

Employment status at booking: : ☐ Employed (full or part-time) ☐ Home ☐ Sick ☐ Student ☐ Unemployed ☐ Retired ☐ Voluntary ☐ Not known ☐ N/A (no partner)

Any documented social/complicating issues (tick all that apply)?

☐ Housing concerns ☐ Intimate partner violence ☐ Drug or alcohol misuse ☐ Mental health issues
☐ Immigration problems ☐ Prison ☐ Sex work ☐ Social services involvement ☐ Learning difficulties
☐ None
☐ Other, details: …….
………

Does the woman speak English? ☐ Yes ☐ No

If yes, is English her first language? ☐ Yes ☐ No, what is her first language?..............................

Were translation services required? ☐ No ☐ Yes*

***If yes, was a formal interpreter used?** ☐ Yes, details of service: ……………………………………………………..

☐ No, reason ……

III. Obstetric history

Previous pregnancies

…….. **livebirth(s)**, date(s) if known: ________________________ …….. **stillbirth(s)** …….. **miscarriage(s)/TOP(s)**

PART 2: PREGNANCY DETAILS

Date referral received by maternity: ____/____/____ **Date booked for antenatal care:** ____/____/____

Maternal weight at booking ……….. kg **maternal height at booking** ……….. cm

Is this an IVF pregnancy? ☐ Yes ☐ No ☐ Not known

Estimated date of delivery (by ultrasound): ____/____/____ and/or **LMP:** ____/____/____

Pregnancy status:
☐ Continuing to term
☐ Miscarriage* – date: ____/____/____ at …….. weeks gestation
☐ Termination* – date: ____/____/____ at …….. weeks gestation
*If miscarriage or termination, any congenital abnormality? ☐ No ☐ Yes: ……………………………………………….

PART 3: ANTENATAL HEPATITIS B SCREENING

Is this a new diagnosis of hepatitis B? ☐ Yes ☐ No
If no, when was the diagnosis of hep B given? (if info available, please provide year)……………….

Date screening sample taken: …./…./…..
Date screening sample tested: ____/____/____
Date screening result (HBsAg) reported to the screening team by the laboratory: …../…../…..

Part 4: THE SCREENING ASSESSMENT VISIT

Date first seen by a member of the screening team: ____/____/____ See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women)

If more than 10 working days between report of result and appointment, reason: …………………..
……

Referral made to specialist team (e.g. Hepatology/Gastroenterology)? ☐ Yes ☐ No, reason:
……………………………………………………………………………

Has the hepatitis B maternal and neonatal checklist commenced? ☐Yes ☐ No, reason:
…...……………………………

Has the woman been given/been directed to the PHE leaflet 'Hepatitis B. A guide to your care in pregnancy and after your baby is born': Yes/No, reason: ……………………………………..

Has antenatal surveillance sample been taken and sent to PHE Colindale? Yes/No, reason:
……………………………………….

Has the 3rd trimester review visit been arranged? ☐Yes ☐ No, reason:
………………………………………………….

Has a notification letter/communication been sent to:

GP? ☐Yes ☐ No, reason: ………………………..

Child Health Records Department ? ☐Yes ☐ No, reason: ……………………………

Health visitor? ☐Yes ☐ No, reason:………………………………………………………………………………

Blood results
Is this considered to be acute hepatitis B infection? Yes / No / Unknown

Type of test	Date of test	Result: positive	Result: negative
HBV e antigen (HBeAg)	____/____/____	☐	☐
HBV e antibody (anti-HBe)	____/____/____	☐	☐
HBV DNA (viral load)	____/____/____	________________ IU/ml	

Have samples been taken for:

FBC (Full blood count)	☐ Yes	☐ No	☐ Not known
U&E (Urea & electrolites)	☐ Yes	☐ No	☐ Not known
LFTs (Liver Function Tests)	☐ Yes	☐ No	☐ Not known
Clotting	☐ Yes	☐ No	☐ Not known
Hepatitis C	☐ Yes	☐ No	☐ Not known

Infectivity classification (as reported by virologist/laboratory)
☐ Lower infectivity ☐ Higher infectivity
If higher infectivity, was HBIG been ordered: Yes/No, reason:…………………………………

Concurrent maternal infection(s)? ☐ None ☐ Syphilis ☐ HCV ☐ HIV ☐ Other*, specify:
…………………………………………..…………………………
*please inform us if Covid-19 has been suspected/diagnosed in the pregnancy

PART 5: CLINICAL MANAGEMENT

Date first seen by specialist team: ____/____/____
Name of specialist…………………………
Type of specialist: ☐ Hepatology ☐ gastroenterologist ☐clinical nurse specialist ☐ other (please specify)……………………………
If new diagnosis / higher infectivity, was the woman seen within 6 weeks of referral (IDPS S06 standard)
☐Yes ☐ No, reason……………………………………….. ☐ N/A
If lower infectivity, was the woman seen within the 18-week NHS outpatient department target? ☐Yes ☐ No, reason……………………………………….. ☐ N/A

PART 6: ADDITIONAL INFORMATION

COVID-19 vaccine received ☐Yes ☐ No
f 'Yes', please specify below which vaccine, number of doses and dates if known
………………………………………………………………………………