

ISOSS hepatitis B positive antenatal notification

form date 04/22

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, please specify.....
 Not stated

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

Home postcode (leave off last letter):

Country of birth: If country of birth not UK, date of arrival: ___/___/___

- Exact date/year not known, timing: during pregnancy (date not known) <1 year prior to pregnancy
 1-5 years prior to pregnancy 5-10 years prior to pregnancy >10 years prior to pregnancy

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/domestic abuse Drug or alcohol misuse
 Mental health issues Immigration issues (incl refugee/asylum seeker) Prison Sex work
 Social services involvement/safeguarding Learning difficulties Not engaging with healthcare services
 Financial concerns (incl accessing foodbank)
 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

Gravida..... Parity.....+..... Date(s) of previous livebirths if known: _____

Obstetric history not known

PART 2: PREGNANCY DETAILS

Date booked for antenatal care: ___/___/___ Unbooked (arrived in labour)

Was there a delay to the woman being booked No Yes, reason

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

Was infectious diseases screening offered and accepted for all infections? Yes No, reason.....

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 result (HBsAg) reported to the screening team by the laboratory:/...../.....

Previously screened negative in **this** pregnancy? date of screen negative result ___/___/___

PART 4: THE SCREENING ASSESSMENT VISIT

Date first seen by a member of the screening team: ___/___/___

Was the woman seen by screening team within 10 working days? Yes No, reason:

[See Screening Standard IDPS-S05 \(referral: timely assessment of screen positive and known positive women\)](#)

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

If not referred is she already under care of specialist team who are aware she is pregnant? Yes No

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

Has the woman been given/been directed to [the 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 UK HSA 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

Please provide test results from screening sample/earliest results in pregnancy:

Type of test	Date of test	Result	
		positive	negative
HBV e antigen (HBeAg)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HBV e antibody (anti-HBe)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HBV DNA (viral load)	___/___/___	_____IU/ml*	

* please provide viral load in IU/ml, for help with converting viral loads if provided in another format please see the [ISOSS Hepatitis B viral load conversion table](#)

Please indicate in the notes if you don't have access to one or more of these results (with a reason)

Have samples been taken for:

	Yes	No	Not known
Full blood count (FBC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urea & electrolytes (U&E)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Function Tests (LFTs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hepatitis C?

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 18week NHS outpatient department target? Yes No, reason..... N/A

Was this woman on hepatitis B treatment at conception? Yes No

Details of treatment (please include all drugs and start dates):

PART 6: ADDITIONAL INFORMATION

COVID-19 vaccine received Yes No

If 'Yes', please specify below which vaccine, number of doses and dates if known

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