

ISOSS hepatitis B outcome – higher infectivity

form date 04/23

CONFIDENTIAL

Woman's NHS no: [Pre-populated] EDD: [Pre-populated] Hospital of delivery:

Maternal postcode at delivery (leave off last letter):

<GP details from notification> Is GP the same? Yes No, details.....

PART 1: NEONATAL DETAILS

Livebirth or Stillbirth (please include details in additional information, part 5)
If twins*, tick here:
*if multiple birth please complete part 6

Date of birth: ___/___/___
Gestational age: ___wks ___days

Male
 Female
 Indeterminate

Child hospital no.: Child NHS no.:

PART 2: PREGNANCY INFORMATION

I. Care in specialist services

Was the woman on treatment at conception? No Yes

Did the woman receive treatment for Hepatitis B during this pregnancy?

No, not required No, other reason..... Yes

Treatment	Before preg?	Date started (or gest. week)	Date stopped (or gest. week)
Drug 1	Yes / No	___/___/___	___/___/___
Drug 2	Yes / No	___/___/___	___/___/___
Drug 3	Yes / No	___/___/___	___/___/___

What was the viral load at commencement of treatment? _____ IU/ml date: ___/___/___

If no result available, reason?

Was a viral load repeated during the pregnancy by specialist team?

Yes, details..... No

II. Care by screening team

Was the woman seen for a screening team review in the 3rd trimester? Yes No, reason:

Was the woman given the UKHSA leaflet '[Protecting your baby against hepatitis B with the hepatitis B vaccine](#)'?

Yes No, reason:

III. Other pregnancy details

Any pregnancy complications?

- None
- Pre-eclampsia
- Gestational diabetes
- Other:

.....
.....

Invasive procedures in pregnancy:

- None Amniocentesis
- CVS Cordocentesis
- Other.....

If yes, date of procedure: ___/___/___

Viral load at time of procedure:

..... copies/ml Date: ___/___/___

Any other infections? (including if Covid-19 has been suspected/diagnosed in the pregnancy)

No Yes, please specify:

Social complicating issues reported at notification: [Pre-populated from notification]

Any additional issues identified by delivery:

- 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:

Part 3: Delivery information

Invasive procedures during labour (tick all that apply):

- None Scalp monitor
- Ventouse, type:
- Forceps, type:
- FBS
- ARM

Rupture of membranes? <input type="checkbox"/> No / Only at delivery <input type="checkbox"/> Yes, duration: hours minutes
Mode of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> ELCS, reason: <input type="checkbox"/> EmCS, reason:
Was the hepatitis B delivery box available at delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason: Did the box contain the named HBIG? Yes/No, reason:
PART 4: NEONATAL INFORMATION
I. Neonatal outcome
Birthweight: kg
Congenital anomalies? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:
Other neonatal infections? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:.....
Any other neonatal complications? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify details:.....
Admitted to Neonatal Unit? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:.....
II. Neonatal follow-up
Was the UKHSA hepatitis B dried blood spot (DBS) taken prior to administration of HBIG and vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason.....
Was hepatitis B vaccination given within 24 hours of birth? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason..... If not within 24 hours, duration after birth..... hours
Was HBIG given within 24 hours of birth? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason..... If not within 24 hours, duration after birth..... hours
Was the UKHSA delivery suite box, completed forms and samples returned to the screening team? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:
Were the completed forms and samples returned to UKHSA Colindale? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:
Has a notification letter/communication been sent to: GP? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason: Child Health Records Department? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason: Health visitor? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:.....
Has the baby been referred to paediatric care? <input type="checkbox"/> No (being followed up by GP) <input type="checkbox"/> Yes, Name of clinician.....
PART 5: ADDITIONAL INFORMATION

Please complete part 6 in the case of a twin pregnancy.

PART 6: CHILD INFORMATION FOR SECOND TWIN	
<input type="checkbox"/> Livebirth or <input type="checkbox"/> Stillbirth	Date of birth: ___/___/___ Gestational age: ___wks ___days
Child hospital no.: Child NHS no.:	
Birthweight: kg	
Congenital anomalies? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:	
Other neonatal infections? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:.....	
Any other neonatal complications? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify details:.....	
Admitted to Neonatal Unit? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify details:.....	