ISOSS hepatitis B outcome – higher infectivity

form date 04/22

CONFIDENTIAL

Mother'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 mother on treatment at conception? ☐ No ☐ Yes

Did the mother 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? ……..

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 PHE 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: ……

Maternal weight in 3rd trimester …….. kg **date**: _____/____ /_____

Maternal weight at booking [pre-populated].. kg **Maternal height at booking** [pre-populated]... cm

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
☐ Ventouse, type: ……
☐ Forceps, type: ……
☐ Scalp monitor
☐ FBS
☐ ARM

Rupture of membranes? ☐ No / Only at delivery ☐ Yes, duration: ..... hours ..... minutes

Any complications in labour: ☐ No ☐ Yes, details: .....

Mode of delivery:
☐ Vaginal ☐ ELCS, reason: ..... ☐ EmCS, reason: .....

Was the hepatitis B delivery box available at delivery? ☐Yes ☐ No, reason: .....
Did the box contain the named HBIG? Yes/No, reason: .....

PART 4: NEONATAL INFORMATION

I. Neonatal outcome

Birthweight: ..... kg **Head circumference:**.....cm

Congenital anomalies? ☐ No ☐ Yes, specify details: .....
Other neonatal infections? ☐ No ☐ Yes, specify details:.....
Any other neonatal complications? ☐ No ☐ Yes: specify details:.....
Admitted to Neonatal Unit? ☐ No ☐ Yes, specify details:.....

II. Neonatal follow-up

Was the PHE hepatitis B dried blood spot (DBS) taken prior to administration of HBIG and vaccine?
☐ Yes ☐ No, reason.....

Was hepatitis B vaccination given within 24 hours of birth? ☐ Yes ☐ No, reason.....
If not within 24 hours, duration after birth..... hours
Was HBIG given within 24 hours of birth? ☐ Yes ☐ No, reason.....
If not within 24 hours, duration after birth..... hours

Was the PHE delivery suite box, completed forms and samples returned to the screening team?
☐ Yes ☐ No, reason: .....
Were the completed forms and samples returned to PHE Colindale?
☐ 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:.....

Has the baby been referred to paediatric care? ☐ No (being followed up by GP) ☐ Yes, Name of clinician.....

PART 5: ADDITIONAL INFORMATION

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

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

PART 6: CHILD INFORMATION FOR SECOND TWIN

☐ **Livebirth** or ☐ **Stillbirth**	**Date of birth:** ____/____/____ **Gestational age:**___**wks** ___**days**

Child hospital no.: ..... **Child NHS no.:** .....

Birthweight: ..... kg **Head circumference:**.....cm

Congenital anomalies? ☐ No ☐ Yes, specify details: .....
Other neonatal infections? ☐ No ☐ Yes, specify details:.....
Any other neonatal complications? ☐ No ☐ Yes: specify details:.....
Admitted to Neonatal Unit? ☐ No ☐ Yes, specify details:.....