

ISOSS hepatitis B outcome – lower infectivity

form date 07/21

CONFIDENTIAL

Your ref: [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 i) and ii)

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 a viral load repeated during the pregnancy? Yes No, 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 (or directed to online) '[Protecting your baby against hepatitis B with the hepatitis B vaccine](#)': Yes No, reason:

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

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

Labouring in pool but not delivered in pool

Yes No

Labouring and delivered in pool

Yes No

Any complications in labour: No Yes, details:

Mode of delivery: Vaginal ELCS, reason: EmCS, 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 hepatitis B vaccination given within 24 hours of birth? Yes No, reason:

If the baby was ≤ 1.5 kg in weight, was HBIG given within 24 hours of birth?

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 Yes, Name of clinician:

PART 5: ADDITIONAL INFORMATION

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

Please complete parts 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
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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:.....